

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

800 08386

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Spencer B. BALTIMORE			2a DATE OF DEATH MONTH DAY YEAR MARCH 16, 1980		2b HOUR 1:10 P.M.
3 SEX M	4 RACE Black	5 DATE OF BIRTH MONTH DAY YEAR 8 23 1913		6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) md.	7b CITIZEN OF WHAT COUNTRY? U.S.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD		
10 CITY OR TOWN OF DEATH EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial		12a USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Laborer	12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b COUNTY 13c CITY OR TOWN md. Caroline Federalsburg			13d INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS	
14 FATHER'S NAME FIRST MIDDLE LAST Thomas A Baltimore			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie H.		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) H	17 INFORMANT ADDRESS Sadie Baltimore			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1629 Ch of lungs DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
---	--	--

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) sew the body after death.		22c. DATE SIGNED
22b. SIGNATURE [Signature]	DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) [Signature]	22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3-24-80	23c. NAME OF CEMETERY OR CREMATORY Md. Veteran's	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Dorchester md.
24 FUNERAL DIRECTOR NAME Perry Reese Reese Funeral Home		ADDRESS north st. Milford Del.	25a. DATE REC'D. BY REGISTRAR APR 8 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

REPORT OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 18, 1899  
AND  
BY THE ASSEMBLY  
MAY 18, 1899  
ALBANY:  
J. B. LIPPINCOTT & CO. PRINTERS  
1899



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EFFIE M. BENNETT</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>3/25/80</b>			2b. HOUR <b>4:20 A.M.</b>	
3. SEX <b>female</b>		4. RACE <b>caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 14, 1893</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>86</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>TALBOT</b> MD.			
10. CITY OR TOWN OF DEATH <b>EASTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN <b>Maryland Talbot Easton</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>R.D. #3, Box 342</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Levin Graham</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Naomi Myers</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>					16b. SOCIAL SECURITY NO <b>219-07-6973</b>		17. INFORMANT ADDRESS <b>Ralph W. Hollingshead see item 13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Progressive cerebral arteriosclerosis</b> <b>4370</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 mo</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (my hospital) attended the deceased from <b>12-6</b> 19 <b>71</b> to <b>3-25</b> 19 <b>80</b> that (I) (we) last saw the deceased alive on <b>3-28</b> 19 <b>80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Stephen P. Carney</b>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>3-28-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stephen P. Carney, M.D.</b>					22e. ADDRESS <b>Easton, Md. 21601</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3-27-1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mardela Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Mardela, Wicomico, Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Newnam Funeral Home</b>					ADDRESS <b>Easton, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 2 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCready</b>

BP



Stephen E. Carney, D.D. Easton, W. 21601

Newman Funeral Home Easton, W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>Daniel Ouer Blades</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>3 - 19 - 80</b>			2b. HOUR <b>6:45</b> AM	
3 SEX <b>male</b>		4 RACE <b>caucasian</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Mar. 4, 1904</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot County</b> MD.			
10 CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>waterman</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Talbot</b>		13c. CITY OR TOWN <b>Trappe</b>		13e. STREET ADDRESS <b>R.D. #1, Box 26</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>William Blades</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Georgianna Harrison</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-05-0647</b>		12 INFORMANT ADDRESS <b>Harriet M. Ferguson see item 13</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery, Heart Dis.</b> <b>4149</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Circumstances of Death</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <del>this hospital</del> attended the deceased from <b>October 25, 1975</b> to <b>March 19, 1980</b> , that (I) <del>we</del> last saw the deceased alive on <b>March 19, 1980</b> , and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above; (I) <del>we</del> did (did not) view the body after death.									
22b. SIGNATURE <b>R. Lane Wroth, M.D.</b>					DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3-20-80</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. Lane Wroth, M.D.</b>					22e. ADDRESS <b>St. Michaels, Md. 21663</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-22-1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Tilghman Methodist</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Tilghman, Talbot, Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Newham Funeral Home Easton, Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>3-24-1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

1900

1901

1902

1903

1904

1905

1906

1907

1908

1909

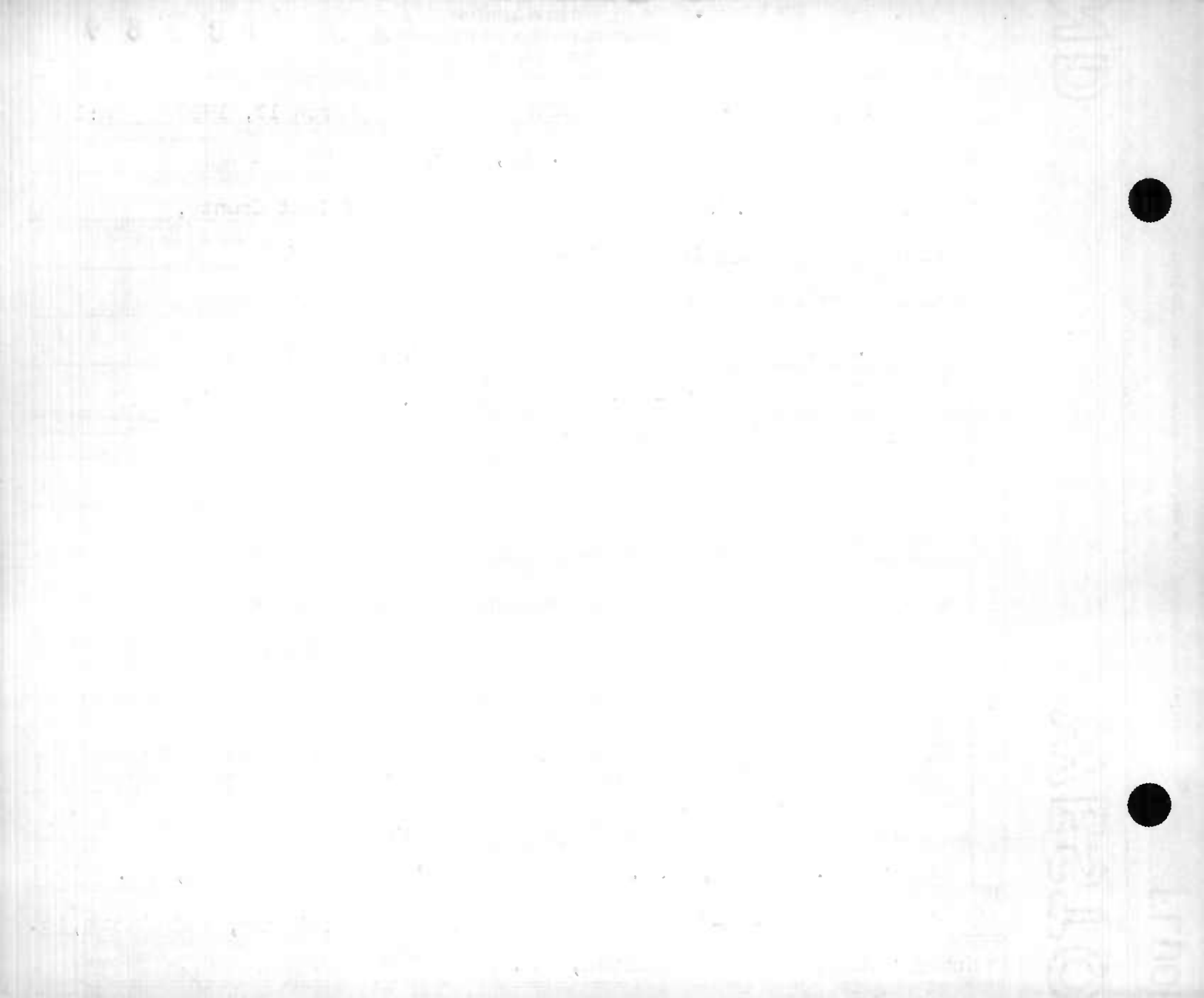
TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of date.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR										
REG. NO.										
1. DECEASED NAME (TYPE OR PRINT) HELEN D. BOND					2a. DATE OF DEATH MONTH DAY YEAR March 13, 1980			2b. HOUR 6:15P M		
3 SEX female		4 RACE caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 27, 1923		6 AGE (IN YEARS LAST BIRTHDAY) 57		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot County, MD.				
10 CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) House in the Pines				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 224 Wye Avenue		
14 FATHER'S NAME FIRST MIDDLE LAST Edgar N. Dunnock					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Hartwell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-20-9285		17. INFORMANT ADDRESS Bernard R. Bond see item 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Alzheimer - Rich Disease</u> 3310 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YRS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from <u>July</u> 19 <u>78</u> , to <u>13 Mar</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>11 Mar</u> 19 <u>80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Stephen P. Carney</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3-17-80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, M.D.					22e. ADDRESS Dutchman's Lane Easton, Md. 21601					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3-17-1980		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Baltimore, Md.			
24. FUNERAL DIRECTOR NAME Newnam Funeral Home					ADDRESS Easton, Md.		25a. DATE REC'D. BY REGISTRAR MAR 20 1980		25b. REGISTRAR'S SIGNATURE <u>Anthony McBrady</u>	

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Eva C Bowdle</b>					2a. DATE OF DEATH MONTH <b>B</b> DAY <b>26</b> YEAR <b>80</b>			2b. HOUR <b>7 25</b> <sup>PM</sup>					
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH <b>5</b> DAY <b>2</b> YEAR <b>12</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		8. IF UNDER 24 HRS HOURS <b></b> MIN <b></b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> <sup>MD</sup>							
10. CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <b>Maryland</b>					13b. COUNTY <b>Talbot</b>		13c. CITY OR TOWN <b>Easton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <b>R.D. #5, Box 390</b>	
14. FATHER'S NAME FIRST <b>Frank</b> MIDDLE <b>Carroll</b> LAST <b></b>					15. MOTHER'S MAIDEN NAME FIRST <b>Eva</b> MIDDLE <b>Stinchcomb</b> LAST <b></b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>216-46-8750</b>		17. INFORMANT ADDRESS <b>Alexander Bowdle, Jr. Easton, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2/10 min</b>			
4/10- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>acute myocardial infarction</b>										DUE TO, OR AS A CONSEQUENCE OF <b>4 hr</b>			
(c) <b></b>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>Hypertensive Cardiovascular disease</b>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>12-31</b> , 19 <b>75</b> , to <b>3-26</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>1-7</b> , 19 <b>80</b> , and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>(I)</b> (we) <b>(did)</b> (did not) view the body after death.													
22b. SIGNATURE <b>Robert W. Traver, M.D.</b>					DEGREE <b></b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3-26-80</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT W. TREVER MD</b>					22e. ADDRESS <b>R D 3 Easton, Md 21601</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3-28-1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Easton, Talbot, Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Newnam Funeral Home</b>					ADDRESS <b>Easton, Md.</b>			25a. RECEIVED BY REGISTERAR <b>APR 2 1980</b>		25b. REGISTERAR'S SIGNATURE <b>[Signature]</b>			



FOR STATE  
HEALTH DEPT.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0 8 3 9 1

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH				2b. HOUR		
Delmus M. Bramble						Month Day Year				c 6 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD				2d. HOUR
M	W	3-26-39	40 YRS.	MONTHS	DAYS	HOURS	MIN	Month Day Year				1 15 M
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.
DORCHESTER COUNTY, MD			USA						Talbot			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Easton			The Memorial Hospital			SOLDIER			US ARMY			
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE			13b. COUNTY			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13d. STREET AND NUMBER			
MD			DORCHESTER						RT 1-Box 217B			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
MAURICE			TENNIE ENSLEY			BRAMBLE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
YES			217-36-2430			JOAN BRAMBLE			RT 1-Box 217B RIEDSGRAVE, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c))												
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Multiple severe injuries												
DUE TO, OR AS A CONSEQUENCE OF												
(b) Into accident												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
				6 3-2 1980				SKIDDED INTO REAR TRACTOR TRAILER				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
		Route 50		NR GRASSTOWN		GA CO.				MD		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED				
Lewis J. Skelly								3-3-80				
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER								
INELTY												
23a. BURIAL DATE				23b. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)				
3/7/80				DORCHESTER MEM. PK.				CAMBRIDGE, DORCHESTER, MD				
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE				
Franklin-Hawkins				MAR 13 1980				H. McCreedy				

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.

1850  
[Faint, mostly illegible handwritten text, possibly a ledger or account book entry. Some words like "received" and "paid" are faintly visible.]

37



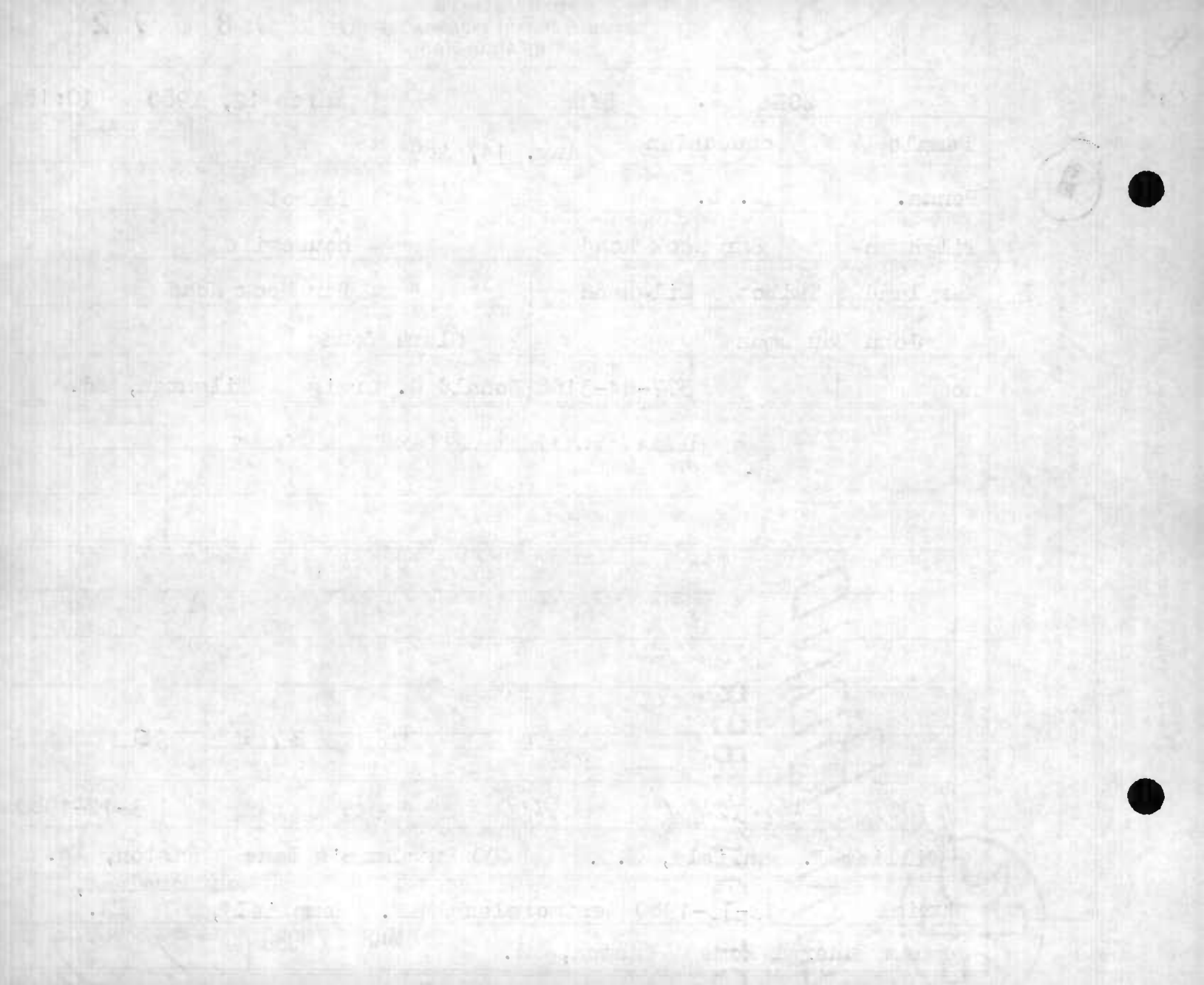
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										08392	
1- FOR STATE REGISTRAR		REG. NO.									
1 DECEASED NAME (TYPE OR PRINT)					2a DATE OF DEATH					2b HOUR	
FIRST MIDDLE LAST ZOLA B. BYERS					MONTH DAY YEAR March 12, 1980					10:15 AM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS.	
female		caucasian		MONTH DAY YEAR Aug. 14, 1895		84 YRS		MONTHS DAYS		HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Penna.		U. S.				Talbot MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Tilghman		Bar Neck Road				housewife					
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS			
Maryland		Talbot		Tilghman		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Bar Neck Road			
14 FATHER'S NAME					15 MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST John Baughman					FIRST MIDDLE LAST Clara Young						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS				
no					577-84-3168		Donald G. Craig Tilghman, Md.				
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/21</u> , 19 <u>78</u> , to <u>3/12</u> , 19 <u>80</u> , that (I) (we) lost <u>11/3</u> , 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22c. SIGNATURE <u>William J. Banfield</u> DEGREE <u>M.D.</u>						22e. ADDRESS 400 Dutchman's Lane Easton, Md.		22d. DATE SIGNED 3-12-1980			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 3-15-1980		23c. NAME OF CEMETERY OR CREMATORY Westmoreland MEM.		23d. LOCATION Westmoreland, PA. CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Newman Funeral Home						ADDRESS Easton, Md.		25a. NAME REC'D. BY REGISTRAR MAR 17 1980			
								25b. REGISTRAR'S SIGNATURE <u>Mark H. Brady</u>			

MEDICAL CERTIFICATION

BP \_\_\_\_\_



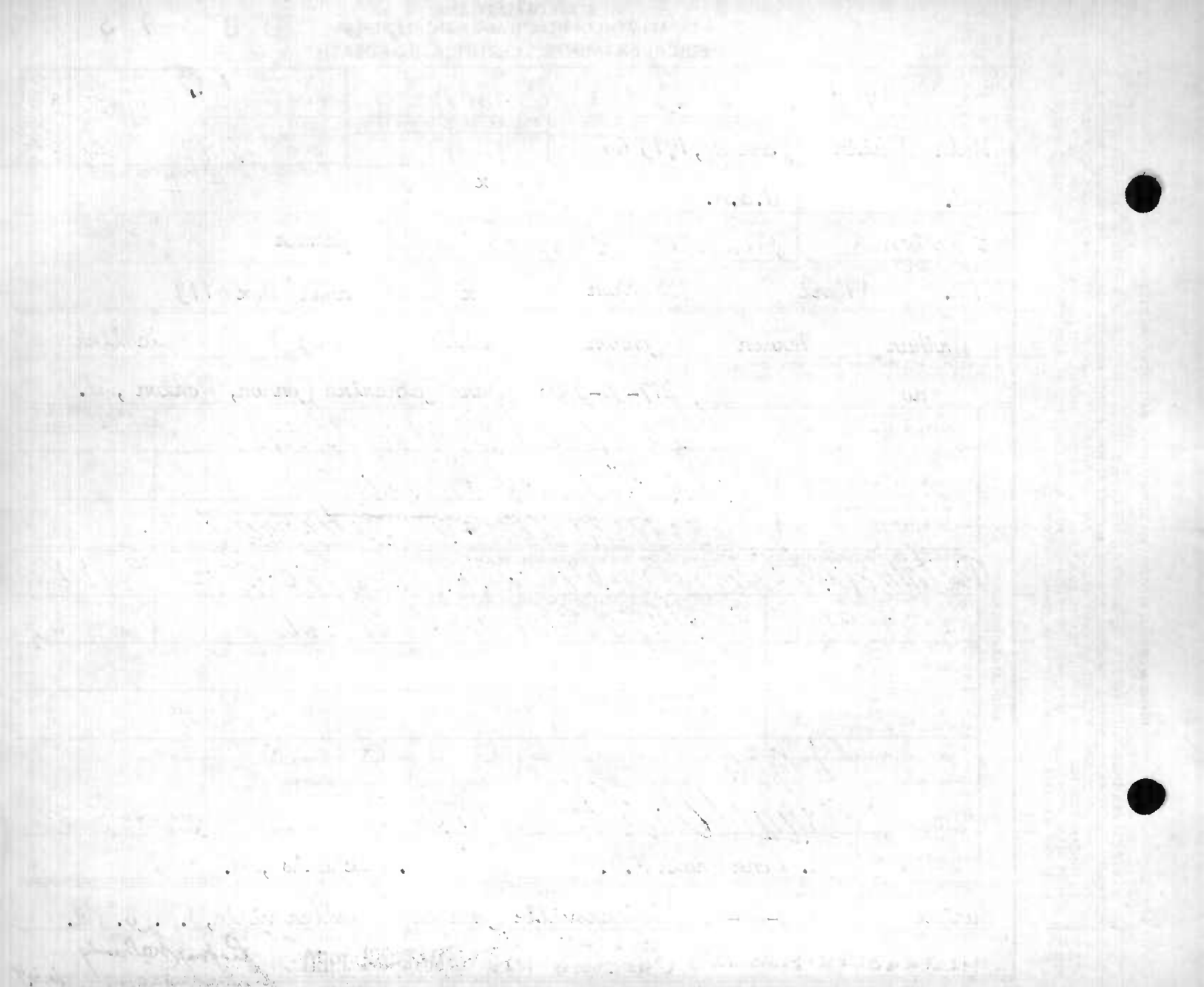


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										08393											
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE KNOWN OF DEATH										2b. HOUR											
FIRST MIDDLE LAST Willard W Cannon										MONTH DAY YEAR Mar. 17 1980										8:29 AM											
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR																	
Male		White		June 29, 1913		66		MONTHS DAYS HOURS MIN.				3-17 1980		8:29 AM																	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH																			
Md.				U.S.A.								Talbot																			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY																			
Easton				Memorial Hospital				Farmer																							
13a. STATE										13b. CITY OR TOWN										13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS									
Md.										Kent										Warton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		none Box #113							
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																					
FIRST MIDDLE LAST Arthur Herman Cannon										FIRST MIDDLE LAST Lilly May Scoller																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)										16b. SOCIAL SECURITY NO.										17. INFORMANT		ADDRESS									
no										217-36-0308										Anna Catherine Cannon		Warton, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																					
PART I DEATH WAS CAUSED BY:																															
IMMEDIATE CAUSE (a)																															
4413																															
DUE TO, OR AS A CONSEQUENCE OF																															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																															
(b)																															
DUE TO, OR AS A CONSEQUENCE OF																															
(c)																															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?											
2-29-80										Ruptured abdominal aorta										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
										P.M. 19																					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:										Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED											
R. Lane Wroth										M.D. R. Lane Wroth										3-18-80											
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS																					
R. Lane Wroth M.D.										St. Michaels, Md.																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial										3-20-80										Sudlersville Cemetery										Sudlersville, O.A. Co. Md.	
24. FUNERAL DIRECTOR NAME										ADDRESS										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE	
HELFENBACH-NUBBARD										Box 67 CHESTER MD.										MAR 24 1980										R. Lane Wroth	





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

08394

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>G WALDO Christopher</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3-25-80</b>			2b. HOUR <b>52</b> MIN <b>12 A M</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 14 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>TALBOT</b> MD.				
10. CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Truck Driver and Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Hurlock</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Harrison Ferry</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Wesley Christopher</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nellie Burke Conway</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII</b>		17. INFORMANT <b>Mrs. Joan Hafner</b>		ADDRESS <b>Hoffman Estates, Ill</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiogenic shock</b> <b>410-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>pulmonary edema + acute myocardial infarction</b> (c) <b>coronary artery disease (ASD)</b> years		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>60 hours</b> <b>75 hours</b>	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>none</b>			

19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>— P.M. — 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>—</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>—</b>		21f. LOCATION STREET <b>—</b>		CITY OR TOWN <b>—</b>	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <b>3/25</b> 19 <b>80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		22b. SIGNATURE <b>Albert T. Dawkins Jr.</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/25/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALBERT T. DAWKINS JR</b>		22e. ADDRESS <b>14 N. AURORA ST EASTON MARYLAND 21601</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			

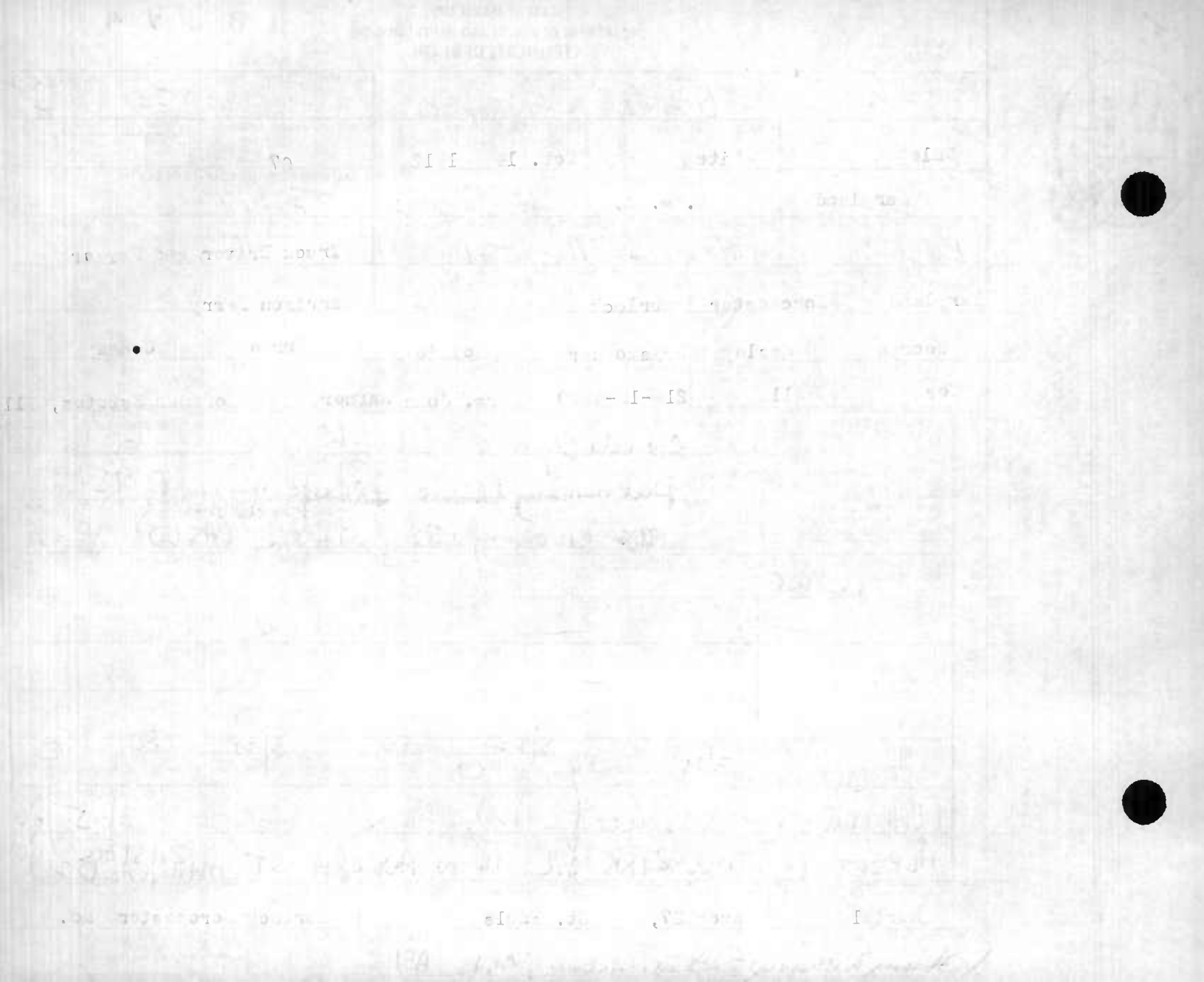
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>March 27,</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls</b>		23d. LOCATION CITY OR TOWN <b>Hurlock</b>		COUNTY <b>Dorchester</b>		STATE <b>Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Henry Watson - Frederick, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>APR 2 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McCreedy</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death, and that it be signed by the attending physician or the registrar.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP



RC 3 21-8-12 5am

Dr. Banfield

M-Laurance Driggs -

12

168542 4/18/80

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

1 - STATE REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)

2a DATE OF DEATH MONTH DAY YEAR

2b HOUR

1 SEX

4 RACE

5 DATE OF BIRTH MONTH DAY YEAR

6 AGE (IN YEARS LAST BIRTHDAY)

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b CITIZEN OF WHAT COUNTRY?

8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

10 CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

13b. COUNTY

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS

14. FATHER'S NAME FIRST MIDDLE LAST

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

17 INFORMANT ADDRESS

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☒ AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (1) (this hospital) attended the deceased from 11/26 19 79 to 3/21 19 80, that (1) (we) lost

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION CITY OR TOWN COUNTY STATE

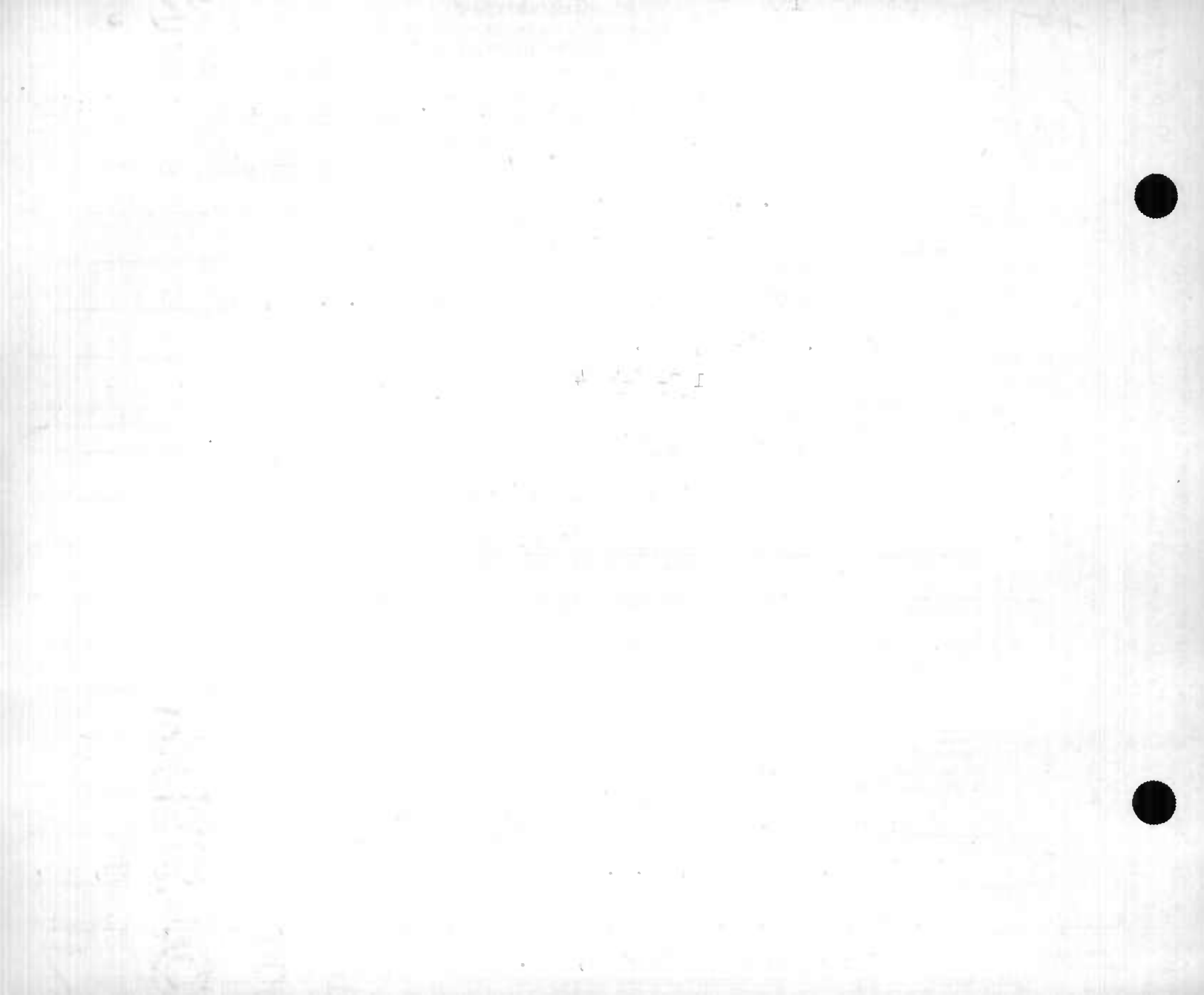
24 FUNERAL DIRECTOR NAME ADDRESS

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

BP

DHMH-16 20M (VRA 15, 4) 7/78



1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Ethel C. Finn</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 21 1980</b>			2b. HOUR <b>3:30 P.M.</b>		
3. SEX <b>female</b>		4. RACE <b>caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 7, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mass.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.		
10. CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Memorial Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MASS.</b>				13b. COUNTY <b>Plymouth</b>		13c. CITY OR TOWN <b>Pembroke</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>George P. Carey</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maude M. Slattery</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>021-38-2108</b>		17. INFORMANT ADDRESS <b>R.D. #4, Box 318 Easton, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Severe Left Lung Pneumonia</b> <b>486-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Severe Chronic Obstructive Lung Disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b> <b>1 wk</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>3/21/80</b> to <b>3/22/80</b> , that (I) (we) lost saw the deceased alive on <b>3/21/80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.								
22b. SIGNATURE <b>[Signature]</b> MD				DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/22/80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. GREGG RHODES MD</b>				22e. ADDRESS <b>14 N. Annapolis - Easton, Md 21601</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-27-1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Malden, Middlesex, Mass.</b>		
24. FUNERAL DIRECTOR NAME <b>Newnam Funeral Home</b>				ADDRESS <b>Easton, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1980</b>		

58  
78  
58  
72  
3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of" are visible.]*

DR. GREGG RHODES MD

THE M. J. JONES

THE M. J. JONES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 08397					
1. DECEASED NAME (TYPE OR PRINT) <b>James E Fletcher</b>					2r. DATE OF DEATH MONTH <b>3</b> DAY <b>22</b> YEAR <b>80</b> 2b. HOUR <b>2:00 PM</b>					
3. SEX <b>Female</b>		4. RACE <b>NC920</b>		5. DATE OF BIRTH MONTH <b>10</b> DAY <b>8</b> YEAR <b>01</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS		7. UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot County</b> MD				
10. CITY OR TOWN OF DEATH <b>Easton, md</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Easton Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laboer</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13r. STATE <b>MD</b>		13b. COUNTY <b>Talbot</b>		13c. CITY OR TOWN <b>Cardue</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt 1 Box 295</b>		
14. FATHER'S NAME FIRST <b>Anderson</b> MIDDLE <b>Fletcher</b> LAST <b></b>					15. MOTHER'S MAIDEN NAME FIRST <b>Emma</b> MIDDLE <b></b> LAST <b></b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>					16b. SOCIAL SECURITY NO. <b>218-2-1288</b>		17. INFORMANT ADDRESS <b>Marie Reid</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>MULTIPLE MYELOMA &amp; RENAL FAILURE</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 wks</b>		
2030 DUE TO, OR AS A CONSEQUENCE OF (b) <b></b>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b></b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from <b>JUN 19 76</b> , to <b>22 MAR 19 80</b> , that (I) (we) last saw the deceased alive on <b>22 MAR 19 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22a. SIGNATURE <b>Stefan P. Cunningham</b>					DEGREE		22c. DATE SIGNED <b>3-23-80</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <b>3/28/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chapel</b>		23d. LOCATION CITY OR TOWN <b>Easton</b> COUNTY <b>Talbot</b> STATE <b>MD</b>			
24. FUNERAL DIRECTOR NAME <b>Thomas A. Dashiell</b> ADDRESS <b>Easton MD</b>					25a. DATE REC'D. BY REGISTRAR <b>APR 01 1980</b> 25b. REGISTRAR'S SIGNATURE <b>Anthony M. Brady</b>					

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11



FOR STATE  
HEALTH DEPT.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08398

1. DECEASED-NAME (Type or Print) First: John Middle: W. Last: Green			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month: 3 Day: 4 Year: 1980			2b. HOUR OF DEATH: 5:17 M		
3. SEX: Male	4. RACE: Negro	5. DATE OF BIRTH: 11/20/25	6. AGE (In years last birthday): 54 YRS.	IF UNDER 1 YEAR: MONTHS: DAYS: HOURS: MIN.	2c. DATE PRONOUNCED DEAD: Month: 3 - Day: 4 - Year: 1980			2d. HOUR: 5:18 M
7a. BIRTHPLACE (State or foreign country): Md		7b. CITIZEN OF WHAT COUNTRY?: USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH: Talbot Md.		
10. CITY OR TOWN OF DEATH: EASTON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Memorial Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Laborer		12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md			13b. COUNTY: Caroline	13c. CITY OR TOWN: Preston	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER: Kaubach Box 15-		
14. FATHER'S NAME First: Medford Middle: Green Last: Green			15. MOTHER'S MAIDEN NAME First: Nora Middle: Friend Last: Friend					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No			16b. SOCIAL SECURITY NO.:		17. INFORMANT: Ernestine Green ADDRESS:			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4149 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <del>Chronic Cardiac Disease</del> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Carcinoma of Rectum								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:
19a. DATE OF OPERATION:			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH:		21b. TIME OF INJURY Month, Day, Year: P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.):				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.):		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE: [Signature] EXAMINER'S NAME (Type):			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED: 3-4-80		
23a. BURIAL, CREMATION, REMOVAL (Specify):			23b. DATE: 3/8/80	23c. NAME OF CEMETERY OR CREMATORY: Mt Pleasant		23d. LOCATION (City or Town) (County) (State): Preston Cal. Md.		
24. FUNERAL DIRECTOR: [Signature] ADDRESS:			25a. REC'D BY REGISTRAR: DATE: MAR 12 1980			25b. REGISTRAR'S SIGNATURE: [Signature]		

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with pages 1, 2, and 3.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.  
Page 5 may be retained for your files.

2022 EDITION 1822

THE GYM DOWD



*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified first.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR					REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) <i>Josephine E. Harrison</i>					2a DATE OF DEATH MONTH DAY YEAR <i>3-10-1980</i>				
3 SEX <i>female</i>		4 RACE <i>caucasian</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>June 13, 1890</i>		6 AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS <i>89</i>		2b HOUR <i>8:45 AM</i>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i> MD.			
10 CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Memorial Hospital</i>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>housewife</i>		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE <i>Maryland</i>		13b COUNTY <i>Talbot</i>		13c CITY OR TOWN <i>Easton</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS <i>R.D. #5, Box 685</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>Joseph Bindok</i>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Josephine Yanoladuk</i>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>					16b SOCIAL SECURITY NO. <i>214-74-1057</i>		17 INFORMANT ADDRESS <i>James L. Harrison, Jr.</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Respiratory Failure</i> <i>515-</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pulmonary Fibrosis and Bronchectasis</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>ASCVD and CVA ; Fractured hip</i>									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <i>2-19</i> , 19 <i>80</i> , to <i>3-10</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>3-9</i> , 19 <i>80</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <i>Terry P. Detrich M.D.</i>						DEGREE <i>M.D.</i>		22c DATE SIGNED <i>3-10-80</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Terry P. Detrich, M.D.</i>						22e ADDRESS <i>Washington St., Easton, Md. 21601</i>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b DATE <i>3-13-1980</i>		23c NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cemetery</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Baltimore, Md.</i>		
24 FUNERAL DIRECTOR NAME <i>Newnam Funeral Home</i>						ADDRESS <i>Easton, Md.</i>		25a DATE REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE <i>MAR 13 1980</i>	

CONFIDENTIAL

MEMORANDUM FOR THE DIRECTOR

FROM: SAC, NEW YORK

DATE: 11-11-60

SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

0 8 4 0 0

1. DECEASED-NAME (Type or print) <b>Walter Edward Harrold</b>			2a. DATE OF DEATH Month <b>March</b> Day <b>6</b> Year <b>1980</b>		2b. HOUR <b>5:52</b> PM
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>July 12, 1900</b>		6. AGE (In years lost birthday) <b>79</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>England</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Talbot</b> Md.	
10. CITY OR TOWN OF DEATH <b>Easton</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Memorial Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE <b>Maryland</b>		13b. COUNTY <b>Caroline</b>	13c. CITY OR TOWN <b>Denton</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>Rt. 2 Box 183</b>
14. FATHER'S NAME First Middle Last <b>Samuel Harrold</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>(unknown) Shaw</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216182099</b>		17. INFORMANT Address <b>Carrie Harrold, Rt. 2 Box 183, Denton</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF <b>acute</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular dis</b> <b>chronic</b> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <b>Actual fibrillation, Chronic obstructive Lung Disease</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>5/26/73</b> to <b>3/6/80</b> , that (I) (we) last saw the deceased alive on <b>3/5/80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <b>Christian E. Jensen MD</b>		22c. DATE SIGNED <b>3/04/80</b>		22d. PHYSICIAN'S NAME (Type) <b>Christian E. Jensen, M.D.</b>	
22e. ADDRESS <b>Kerr Avenue, Denton, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>3/10/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cape Henlopen Crematory Lewes, Sussex Del.</b>	
23d. LOCATION (City or Town) (County) (State) <b>Denton, Maryland</b>					
24. FUNERAL DIRECTOR <b>MOORE FUNERAL HOME</b>		ADDRESS <b>DENTON, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 13 1980</b>	
25b. REGISTRAR'S SIGNATURE <b>Pinkney McCreedy</b>					

Chief Financial Officer  
Department of Finance  
City of New York

2010-2011  
Fiscal Year



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8008401	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Delsya Pearl Hickey</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 21 1980</b>			2b. HOUR <b>6:25 AM</b>		
3 SEX <b>Female</b>		4 RACE <b>Cau.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12-24-1892</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.					
10 CITY OR TOWN OF DEATH <b>EASTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>none</b>			
13a. STATE <b>Md.</b>		13b. COUNTY <b>Caroline</b>		13c. CITY OR TOWN <b>Greensboro</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>N. Main St.</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>Isaac Everett</b>						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Chase</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>180-03-2949</b>		17 INFORMANT ADDRESS <b>Elizabeth Hichey Greensboro, Md.</b>							
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF <b>disease with</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>failure</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs.</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>None</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <b>1-21</b> , 19 <b>76</b> , to <b>3-21</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Robert W. Trever, M.D.</b>						DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3-21-80</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS <b>RD 3 Easton Md. 21601</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-25-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Templeville</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Templeville Caroline Md.</b>					
24. FUNERAL DIRECTOR NAME <b>John E Boula's Greensboro Md</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 28 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Robert W. Trever</b>			

BP

Female

Can.

12-24-1892

87

MI.

U.S.A.

x

Housewife

none

MA.

Carolina Greenboro

x

M. Main St.

Isaac Everett

Isaac Chase

no

180-03-2949

Elizabeth Hickey

Greenboro, N.C.

Burial

1-22-80

Tombville

Tombville Caroline



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE				0 8 4 0 2			
1 - STATE REGISTRAR				CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
FIRST MIDDLE LAST Louis Henry Jones				MONTH DAY YEAR 3 21 80				3 05 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		7. UNDER 24 HRS	
Male		White		January 13, 1902		78		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.		U.S.A.				TALBOT MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
EASTON		EASTON MEMORIAL				workman		Seafood			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. INSIDE CITY LIMITS?				13c. STREET ADDRESS			
13a. STATE CITY OR TOWN				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				Rt 1 Box 204			
13a. STATE CITY OR TOWN				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				Rt 1 Box 204			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST Louis Elmer Jones				FIRST MIDDLE LAST Grace Benton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS			
no		216-18-2981		Mrs. Catherine Harris Jones, Chester, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Congestive Heart Failure											
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart											
DUE TO, OR AS A CONSEQUENCE OF (c) Disease											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):											
None											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from 1-10 1980, to 3-21 1980, that (2) I saw the deceased alive on 3-21 1980, and that in my opinion death occurred on the date and hour and from the causes stated above. (If you did not view the body after death, so state.)											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
Robert W. Trever, M.D.								3-21-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
				RD 3 Easton, Md. 21601							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		3-24-80		Stevensville, Cemetery		Stevensville, Q.A. Co. Md.					
24. FUNERAL DIRECTOR NAME				ADDRESS				DATE REC'D BY REGISTRAR			
HELEN HUBBARD FUNERAL HSE - BALTIMORE				CHESTER MD				MAR 26 1980			

BP \_\_\_\_\_

208

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR					2a. DATE OF DEATH					2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
FREDERICK N Leonard					3-11-80					11:22 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		7. IF UNDER 24 HRS	
male		caucasian		Oct. 4, 1909		70 YRS		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
New Jersey		U.S.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		TALBOT MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
EASTON		MEMORIAL Hospital				government employee					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
13a. STATE Maryland					13d. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. Evergreen Road				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
Thomas D. Leonard					Lucy Norton						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS				
yes					W.W. 11		Phyllis H. Leonard Oxford, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for a), b), and c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Melastolic Carcinoma of Prostate											
DUE TO, OR AS A CONSEQUENCE OF (b)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Parkinson's Disease											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			HOUR A.M. MONTH DAY YEAR								
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>			[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]			STREET CITY OR TOWN COUNTY STATE					
AT WORK AT WORK											
22a. I certify that (I) (this hospital) attended the deceased from 3/11/80 to 3/11/80, that (I) (we) last saw the deceased alive on 3/11/80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE					DEGREE			22c. DATE SIGNED			
Wm H Wood Jr					MD			3/12/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS						
Wm H Wood Jr					EASTON Md						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			
Cremation			3-12-1980		Delmarva Crematory			Lewes, Sussex, Delaware			
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Newham Funeral Home					Easton, Md.			MAR 17 1980			

FRANCIS J. ... 1-1-20

TAB 1

EASTON ... Hospital

James D. ...

... 1-1-20 ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or event.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edward HART Loysen			2a. DATE OF DEATH MONTH DAY YEAR 3-19-80			2b. HOUR 10 <sup>10</sup> <sub>A</sub> M			
3 SEX MALE		4 RACE CAU		5. DATE OF BIRTH MONTH DAY YEAR SEPT 15, 1905		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.			
10 CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital at Easton MD INC				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EQUIFAX-MGR		12b. KIND OF BUSINESS OR INDUSTRY IN VES.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY TALBOT		13c. CITY OR TOWN ST. MICHAELS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST ABRAM LOYSEN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAUDE DELANO			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO 021-01-5204			17 INFORMANT MARJORIE L. LOYSEN, ST. MICHAELS MD			ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pleural mesothelioma, brain met 1639 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 mo
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21e. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (this hospital) attended the deceased from 6-7 19 80, to 3-19 19 80, that (1) (we) (we) (we) saw the deceased alive on 3-19 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (we) (we) did not view the body after death.									
22b. SIGNATURE Stephen P. Carney			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-19-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN P. CARNEY, M.D.			22e. ADDRESS EASTON, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL CREMATION			23b. DATE MAR 20, 1980		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEME.		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD P.G. MD.		
24. FUNERAL DIRECTOR NAME Harmon E. Leonard			24b. DATE REC'D. BY REGISTRAR MAR 24 1980		25. REGISTRAR'S SIGNATURE Morty McCreedy				

1. 1st Sunday in Lent - Feb. 12th

2. 2nd Sunday in Lent - Feb. 19th

3. 3rd Sunday in Lent - Feb. 26th

4. 4th Sunday in Lent - Mar. 5th

5. 5th Sunday in Lent - Mar. 12th

6. 6th Sunday in Lent - Mar. 19th

7. 7th Sunday in Lent - Mar. 26th

8. 8th Sunday in Lent - Apr. 2nd

9. 9th Sunday in Lent - Apr. 9th

10. 10th Sunday in Lent - Apr. 16th

11. 11th Sunday in Lent - Apr. 23rd

12. 12th Sunday in Lent - Apr. 30th

13. 13th Sunday in Lent - May 7th

14. 14th Sunday in Lent - May 14th

15. 15th Sunday in Lent - May 21st

16. 16th Sunday in Lent - May 28th

17. 17th Sunday in Lent - June 4th

18. 18th Sunday in Lent - June 11th

19. 19th Sunday in Lent - June 18th

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

08405

1. FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)FIRST MIDDLE LAST  
SARA A. LYONS2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR  
MARCH 10, 1980 5:00 AM

3. SEX

female

4. RACE

caucasian

5. DATE OF BIRTH

MONTH DAY YEAR  
NOV. 30, 1900

6. AGE (IN YEARS (LAST BIRTHDAY))

79

7. UNDER 1 YEAR

MONTHS DAYS HOURS MIN

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

TALBOT

MD.

10. CITY OR TOWN OF DEATH

Easton

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
Memorial

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)  
housewife

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13b. STATE

Maryland

13c. COUNTY

Talbot

13d. CITY OR TOWN

Easton

13e. INSIDE CITY LIMITS?

YES ☒ NO ☐

13f. STREET ADDRESS

24 Wrightson Avenue

14. FATHER'S NAME

FIRST MIDDLE LAST  
J. Roy Rittenhouse

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST  
Alvaretta Rittenhouse

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  
no

16b. SOCIAL SECURITY NO.

217-05-3710B

17. INFORMANT

W. Raymond Lyons

ADDRESS

see item 13

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Ca of Colon  
1539

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 7 19 78 to 3/10 19 80, that (I) (we) last saw the deceased alive on 3/10 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE  
William J. Banfield, M.D.

22c. ADDRESS

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐  
Easton, Md. 21601

22d. DATE SIGNED

3-10-80

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

3-12-1980

23c. NAME OF CEMETERY OR CREMATORY

Spring Hill

23d. LOCATION

CITY OR TOWN COUNTY STATE  
Easton, Talbot, Md.

24. FUNERAL DIRECTOR

NAME  
Newnam Funeral Home

ADDRESS

Easton, Md.

15b. DATE REC'D BY REGISTRAR

15c. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



COPIES 41118

10/1/50

10/1/50

10/1/50

10/1/50



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

08406

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Laura</i>	MIDDLE <i>W.</i>	LAST <i>Mc Enery</i>	2a. DATE OF DEATH MONTH DAY YEAR <i>March 23, 1980</i>		2b. HOUR <i>5<sup>50</sup> P M</i>	
3 SEX <i>Female</i>		4 RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>5 15 17</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>62</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i> MD.				
10 CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>The Memorial Hospital</i>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		
13a STATE <i>Md.</i>		13b COUNTY <i>Easton</i>		13c CITY OR TOWN <i>Easton</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <i>523 Goldsboro St.</i>		
14 FATHER'S NAME FIRST MIDDLE LAST <i>Carroll W. West</i>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Effa Blades</i>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. <i>198-26-4078</i>		17 INFORMANT ADDRESS						
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i> <i>4912</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>COPD with Chronic Bronchitis</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 yrs</i> <i>Yrs</i>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>3/22 1980</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the deceased from <i>3/22</i> 19 <i>80</i> to <i>3/23</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>3/22</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <i>Wm H Wood</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <i>3/23/80</i>				
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>WOOD</i>		22e ADDRESS <i>EASTON Md</i>								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>		23b DATE <i>3/24/80</i>		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR NAME <i>Anatomy Board of Md. Baltimore, Md.</i>		ADDRESS		25a DATE OF CO. BY REGISTRAR <i>MAR 28 1980</i>		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>				

BP



470  
JAN 1950



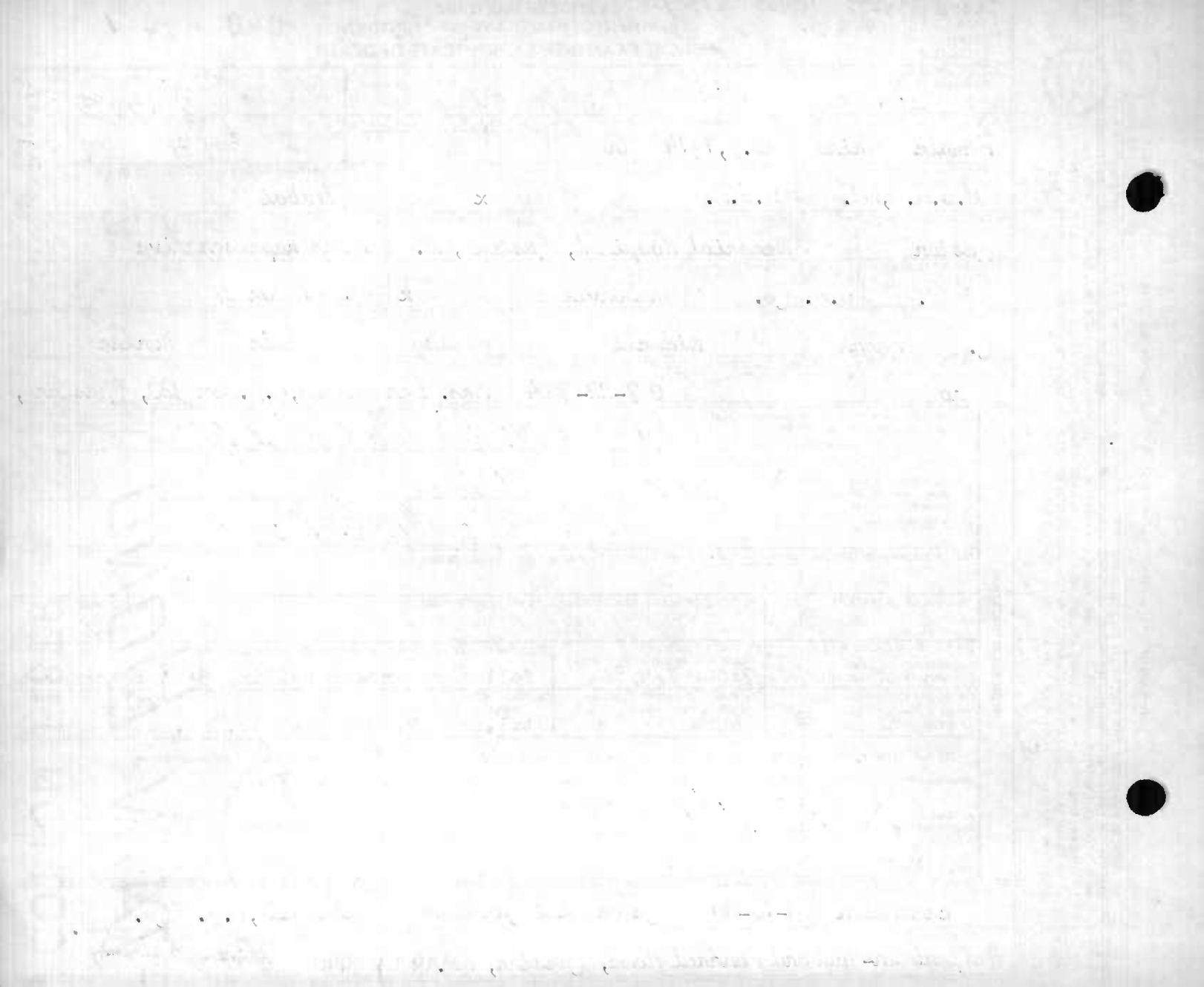
1950  
JAN 1950

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 08407					
1. DECEASED NAME (TYPE OR PRINT) <b>Louise H. McKinney</b>										2a. DATE KNOWN OF DEATH MONTH <b>3</b> DAY <b>13</b> YEAR <b>1980</b>		2b. HOUR <b>8:50</b> AM			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Feb.</b> DAY <b>7</b> YEAR <b>1914</b>		6. AGE (IN YEARS) YRS. <b>66</b>		IF UNDER 24 HRS. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b>		2c. DATE PRONOUNCED DEAD MONTH <b>3</b> DAY <b>13</b> YEAR <b>1980</b>		2d. HOUR <b>8:50</b> AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>U.S.A., Md.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.					
10. CITY OR TOWN OF DEATH <b>Easton</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital, Easton, Md.</b>				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Sales representative</b>				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md.</b>				13b. COUNTY <b>Q.A. Co.</b>		13c. CITY OR TOWN <b>Grasonville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rfd #1 Box 27</b>					
14. FATHER'S NAME FIRST <b>C.</b> MIDDLE <b>Frank</b> LAST <b>Kidwell</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Daisy</b> MIDDLE <b>Belle</b> LAST <b>Hunter</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>087-22-5804</b>		17. INFORMANT <b>Mrs. Lee Murray</b>				ADDRESS <b>P.O. Box 320, Chester, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>882- Subarachnoid hemorrhage</b> IMMEDIATE CAUSE (a) <b>Head Injury</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Alcoholism</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Alcoholism</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7:00 P.M. 3/9/80</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>fell thru broken railing 3'4" to concrete walk</b>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>				21f. LOCATION STREET <b>Rt. 1, Box 27, Grasonville, Md.</b> CITY OR TOWN <b>Grasonville</b> COUNTY <b>Talbot</b> STATE <b>Md.</b>							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE <b>K. Gravelle</b>				TITLE (SPECIFY) <b>M.D.</b>				MEDICAL EXAMINER <b>SC. WROTT</b>				DATE SIGNED <b>3-15-80</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>SC. WROTT</b>				ADDRESS <b>51. MICHAELS IND.</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>cremation</b>				23b. DATE <b>3-16-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>				23d. LOCATION CITY OR TOWN <b>Suitland, P.G. Co. Md.</b> COUNTY <b>Prince Georges</b> STATE <b>Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Helfenbein-Hubbard Funeral Home, Chester, Md.</b> ADDRESS						25a. DATE REC'D. BY REGISTRAR <b>MAR 18 1980</b>				25b. REGISTRAR'S SIGNATURE <b>P. J. McBrady</b>					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
1. FOR STATE REGISTRAR			REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR			
Mary E Meintzer			3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS		
female			caucasian		Jan. 7, 1937		43		YRS.		MONTHS		DAYS		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			10. CITIZEN OF WHAT COUNTRY?			11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			12. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland			U.S.						talbot						
13. CITY OR TOWN OF DEATH			14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			16. KIND OF BUSINESS OR INDUSTRY			MD.			
Easton			The Memorial Hospital			housewife									
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			18. STATE			19. COUNTY			20. CITY OR TOWN			21. INSIDE CITY LIMITS?			
Maryland			Talbot			Easton			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			22. STREET ADDRESS			
23. FATHER'S NAME			24. MOTHER'S MAIDEN NAME			25. ADDRESS			26. P.O. Box 666						
W. Pinkney West, Jr.			Katherin Rommel						Easton, Md.						
27. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			28. SOCIAL SECURITY NO			29. INFORMANT			30. ADDRESS						
no			218-34-0696			Benjamin T. Meintzer									
31. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic failure										4 days					
5715 DUE TO, OR AS A CONSEQUENCE OF (b) Acute & chronic nutritional cirrhosis										4 yrs					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)															
32. DATE OF OPERATION				33. CONDITION FOR WHICH OPERATION WAS PERFORMED				34. AUTOPSY?		35. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
36. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				37. TIME OF INJURY				38. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
				HOUR A.M. MONTH DAY YEAR											
				P.M. 19											
39. INJURY OCCURRED				40. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				41. LOCATION							
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>								STREET		CITY OR TOWN		COUNTY		STATE	
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>															
42. I certify that (I) (this hospital) attended the deceased from 11-13, 1964, to 3-4, 1980, that (I) (we) lost saw the deceased alive on 3-4, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
43. SIGNATURE				DEGREE				44. DATE SIGNED							
Stephen P. Carney								3-4-80							
45. PHYSICIAN'S NAME (TYPE OR PRINT)				46. ADDRESS				47. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
Stephen P. Carney, M.D.				Dutchman's Lane				Easton, Md.							
48. BURIAL, CREMATION, REMOVAL (SPECIFY)				49. DATE		50. NAME OF CEMETERY OR CREMATORY				51. LOCATION					
Burial				3-7-1980		Woodlawn Memorial				Easton, Talbot, Maryland					
52. FUNERAL DIRECTOR				53. DATE REC'D BY REGISTRAR				54. REGISTRAR'S SIGNATURE							
Newnam Funeral Home				MAR 10 1980				[Signature]							
NAME				ADDRESS											
Newnam Funeral Home				Easton, Md.											

MEDICAL CERTIFICATION

MAR 10 1980

Stephen F. Carney, M.D.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

08409

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Agnes V. Miller</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 25, 1980</b>			2b. HOUR <b>4:10 P.M.</b>			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 2, 1908</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>71</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD			
10 CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>-</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>				13b. CITY OR TOWN <b>Queen Anne's Centreville</b>		13c. STREET ADDRESS <b>Rt. #1 Box 94 Centreville</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Benjamin Franklin Quiller</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>L. Honney</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO <b>216-24-3998</b>		17 INFORMANT ADDRESS <b>William Robert Miller Rt. #1 Box 93 Centreville, Md.</b>			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Renal failure</b> 2506 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetes mellitus</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis, generalized, severe</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION <b>3/20/80</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Diabetic Gangrene, left heel</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>3/2/80</b> 19 to <b>3/25/80</b> 19, that (I) (we) last saw the deceased alive on <b>3/25/80</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Johnathon A. Hummel</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/26/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Johnathon A. Hummel M.D.</b>						22e. ADDRESS <b>Box 629 Easton, Md. 21601</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3-28-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chesterfield Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Centreville Queen Anne Md</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Heltenhein-Hobbsd Chester Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 31 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Harvey McCreedy</b>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP



Jonathan A. Hunter, M.D. Box 622 Barton, Md. 21601

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ANNA MARIE MILLER</b>				2a. DATE OF DEATH MONTH <b>3</b> DAY <b>12</b> YEAR <b>80</b>				2b. HOUR <b>8:50 PM</b>	
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH <b>9</b> DAY <b>26</b> YEAR <b>1944</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>35</b> YRS.		6. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>GERMANY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>TALBOT</b> MD.			
10. CITY OR TOWN OF DEATH <b>EASTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>EASTON MEMORIAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>AT HOME</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>				13b. COUNTY <b>CHARLOTTE</b>		13c. CITY OR TOWN <b>DENTON</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>JOHANN</b> MIDDLE <b>MULLER</b> LAST <b>MULLER</b>				15. MOTHER'S MAIDEN NAME FIRST <b>CAROLINE</b> MIDDLE <b>MULLER</b> LAST <b>MULLER</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>218205147</b>		17. INFORMANT NAME <b>Gertha Miller Denton Ind.</b> ADDRESS <b></b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema.</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b> <b>4 yrs</b>	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes Mellitus Generalized Arteriosclerosis</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>3/12</b> 19 <b>80</b> , to <b>3/12</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Wm N Wood</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/13/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WM N Wood</b>				22e. ADDRESS <b>Easton, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/16/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ellington</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Ellington Conn.</b>			
24. FUNERAL DIRECTOR NAME <b>Moore Funeral Home</b> ADDRESS <b>Denton Ind.</b>				25a. DATE REC'D BY REGISTRAR <b>3/16/80</b>		25b. RECEIVED BY REGISTRAR <b>Receiving State Body</b>			

87

Johnnie Walker  
No. 1000  
Mr. J. H. Walker  
1000

Johnnie Walker  
No. 1000  
Mr. J. H. Walker  
1000

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

08411

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>MAURICE EVEREST Newnam Jr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 14 1980</b>			2b. HOUR <b>3:45 AM</b>				
3 SEX <b>male</b>		4 RACE <b>caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 10, 1903</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>77</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.				
10 CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>funeral director</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Talbot</b>		13c. CITY OR TOWN <b>Easton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>R.D. #3, Box 239</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Maurice E. Newnam, Sr.</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna E. Simpson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>214-34-7424</b>		17 INFORMANT ADDRESS <b>Lillian P. Newnam see item 13</b>					

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Metastatic carcinoma</b> <b>1519</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>of the stomach</b> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Uncertain</b>
--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <b>2-11</b> , 19 <b>80</b> , to <b>3-14</b> , 19 <b>80</b> , that (1)(we) last saw the deceased alive on <b>3-13</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Robert W. Trever, M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>3-14-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert W. Trever, M.D.</b>				22e. ADDRESS <b>RD3 Easton, Md. 21601</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-16-1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oxford Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Oxford, Talbot, Md.</b>	
---	--	-------------------------------	--	--	--	--	--

24. FUNERAL DIRECTOR NAME <b>Newnam Funeral Home</b>		ADDRESS <b>Easton, Md.</b>		DATE SIGNED BY REGISTRAR <b>MAR 20 1980</b>		SIGNATURE OF REGISTRAR <i>[Signature]</i>	
--	--	-------------------------------	--	--	--	--	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Request may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1a should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG NO

08412

1 DECEASED NAME (TYPE OR PRINT) <b>LILLIAN E. PANCOAST</b>			2a DATE OF DEATH MONTH DAY YEAR <b>March 9, 1980</b>			2b HOUR <b>8:55AM</b>			
3 SEX <b>female</b>		4 RACE <b>caucasian</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Apr. 30, 1904</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.			
10 CITY OR TOWN OF DEATH <b>Easton,</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>House in the Pines</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE <b>Delaware</b>				13b COUNTY <b>New Castle</b>		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d STREET ADDRESS <b>901 East Avenue</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Fred Morris, Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marilda Wroten</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>222-14-6521</b>		17 INFORMANT ADDRESS <b>Samuel Keil Wilmington, Del.</b>			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>respiratory insufficiency + failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>left lower lobe pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>1 day</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Dist. lymphoma carcinoma + myeloproliferative disorder</b>									
19a DATE OF OPERATION <b>3/9/80</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>lymphoma</b>			19c AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>3/9/80</b> to <b>3/9/80</b> that (I) (we) last saw the deceased alive on <b>3/9</b> 19 <b>80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death)									
22b SIGNATURE <b>Albert T. Dawkins, Jr.</b>						22c DEGREE <b>M.D.</b>		22d DATE SIGNED <b>3/10/80</b>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Albert T. Dawkins, Jr., M.D.</b>						22f ADDRESS <b>N. Aurora St. Easton, Md.</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3-12-1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Riverview</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Wilmington, New Castle, Del</b>		
24 FUNERAL DIRECTOR NAME ADDRESS <b>Newnam Funeral Home Easton, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 14 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Robert M. Brady</b>	



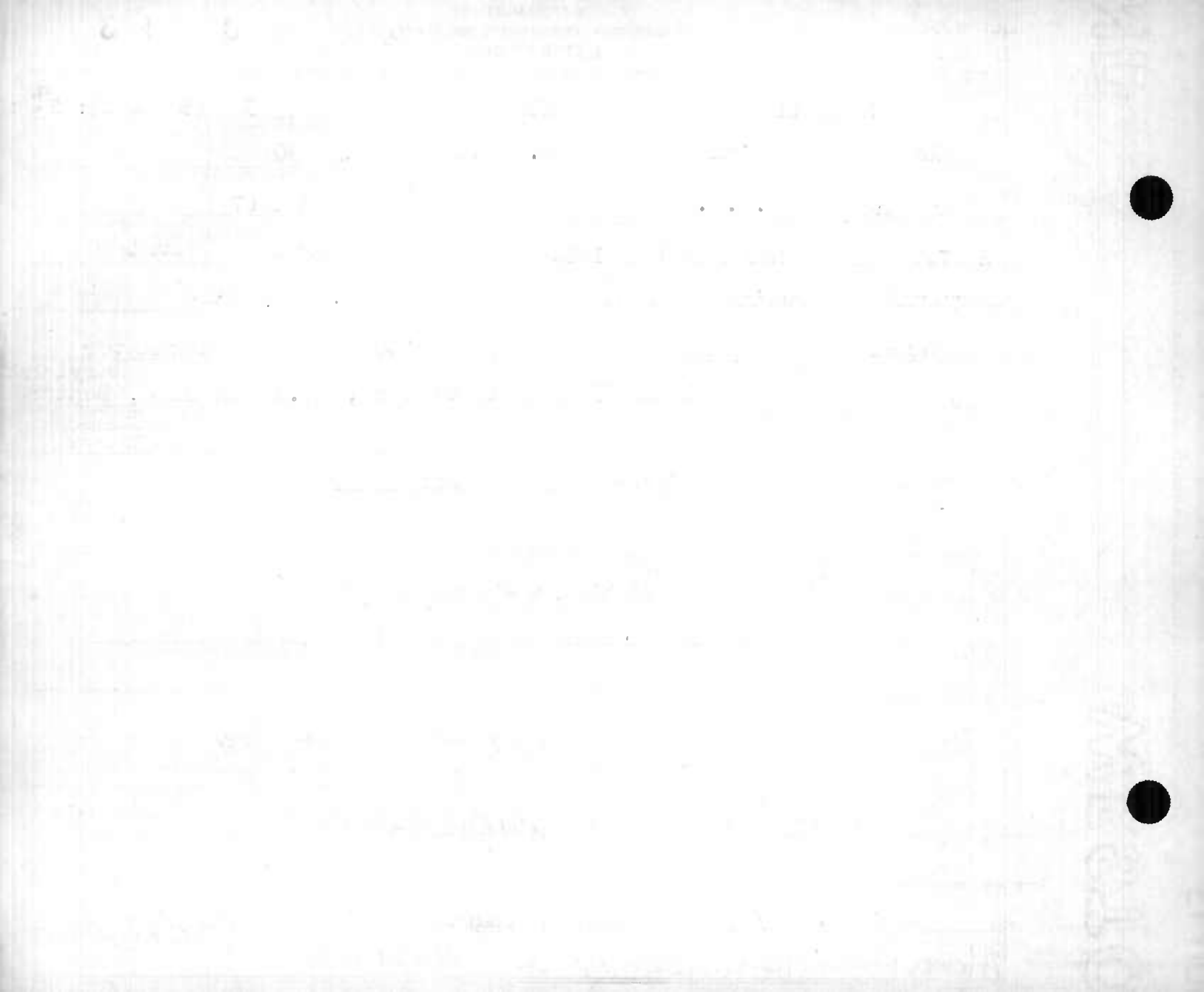
12  
 13  
 14  
 15  
 16  
 17  
 18  
 19  
 20  
 21  
 22  
 23  
 24  
 25  
 26  
 27  
 28  
 29  
 30  
 31  
 32  
 33  
 34  
 35  
 36  
 37  
 38  
 39  
 40  
 41  
 42  
 43  
 44  
 45  
 46  
 47  
 48  
 49  
 50  
 51  
 52  
 53  
 54  
 55  
 56  
 57  
 58  
 59  
 60  
 61  
 62  
 63  
 64  
 65  
 66  
 67  
 68  
 69  
 70  
 71  
 72  
 73  
 74  
 75  
 76  
 77  
 78  
 79  
 80  
 81  
 82  
 83  
 84  
 85  
 86  
 87  
 88  
 89  
 90  
 91  
 92  
 93  
 94  
 95  
 96  
 97  
 98  
 99  
 100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		MIN	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		3 25 80 12:05 PM	
MARSHALL		REED							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		White		Sept. 24, 1889		90 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. MD.	
Maryland		U.S.A.				TALBOT			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
EASTON		HOUSE IN THE PINES		Laborer		Lumber			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Caroline		Denton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. 1 Box 211J	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
Lemuel		Reed		Katherine		Buckmaster			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No		213228873A		Kenneth Reed		Rt. 1 Box 211J, Denton		Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) CVA								2 weeks	
436- DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
Blindness, Healed Pulmonary Tuberculosis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET					
22a. I certify that (I) (this hospital) attended the deceased from 1977 to 3/24/80, that (I) (we) lost saw the deceased alive on 3/20/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
Wm Wood		MD		3/20/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Wood		EASTON MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE	
Burial		3/27/80		Denton Cemetery		Denton		Caroline MD	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
NAME		MAR 28 1980		Anthony McCready					
MOORE FUNERAL HOME PA		DENTON, MD 21629							





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

0 8 4 1 4

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) G. Barnes Reid			2a. DATE OF DEATH MONTH DAY YEAR Mar. 23, 1980			2b. HOUR 6 PM				
3. SEX male		4. RACE caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 5, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.				
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) salesman		12b. KIND OF BUSINESS OR INDUSTRY auto		
13a. STATE MARYLAND			13b. COUNTY TALBOT		13c. CITY OR TOWN St. Michael		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. #33	
14. FATHER'S NAME FIRST MIDDLE LAST William Reid					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena Robinson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 216-03-7498		17. INFORMANT ADDRESS Marlene D. Reid			P.O. Box 110 St. Michaels, Md.		

18. CAUSE OF DEATH (Enter only one cause per item 18a, 18b, and 18c.) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac Arrhythmia DUE TO, OR AS A CONSEQUENCE OF (c) Intermittent Cardiac Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
---	--	---	--

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 25 March 1965 to 23 March 1980, that (I) (we) lost saw the deceased alive on 23 March 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE R. Lane Wroth, M.D.				DEGREE M.D.		22c. DATE SIGNED 3-24-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. Lane Wroth, M.D.				22e. ADDRESS St. Michaels, Maryland 21663			

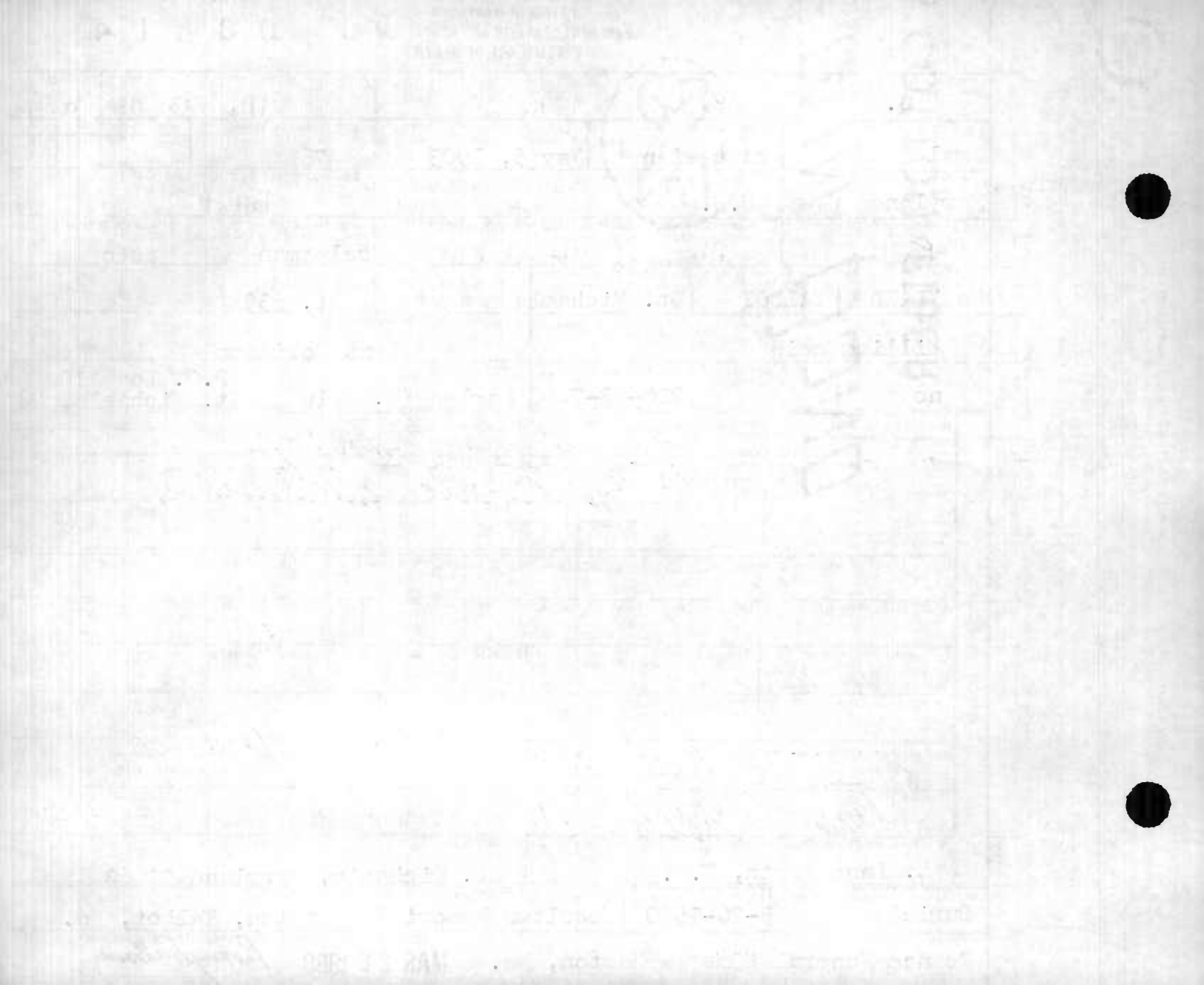
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE 3-26-1980		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Easton, Talbot, Md.	
--	--	------------------------	--	---	--	---	--

24. FUNERAL DIRECTOR NAME Newnam Funeral Home		ADDRESS Easton, Md.		25a. DATE REC'D. BY REGISTRAR MAR 28 1980		REGISTRAR'S SIGNATURE R. Lane Wroth	
---	--	------------------------	--	--	--	--	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

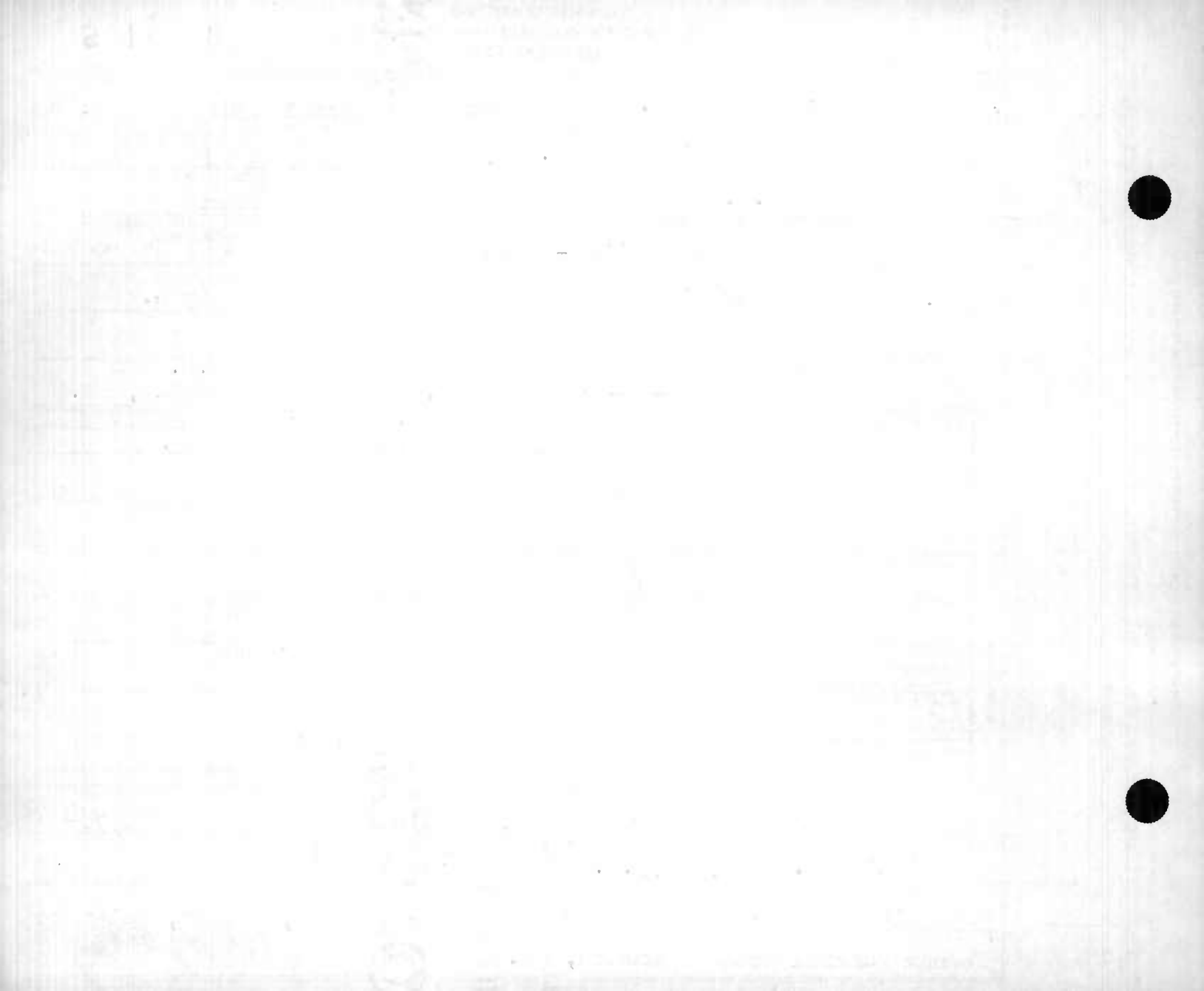


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <b>Elizabeth H. Rhodes</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 16 1980</b>				2b. HOUR <b>8:50A.M.</b>		
3 SEX <b>female</b>		4 RACE <b>caucasian</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Apr. 19, 1904</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot County</b> MD.			
10 CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>House in the Pines-Easton</b>				12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <b>salesperson</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>real estate</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Penna.</b>		13b. COUNTY <b>Alleghany</b>		13c. CITY OR TOWN <b>Pittsburgh</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Cannon Gate Apts.</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Ernest Holsten</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>unknown</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>233-20-5449</b>		17 INFORMANT <b>Frank B. Rhodes</b>		ADDRESS <b>P.O. Box 98 Easton, Md.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CVA with @ hemiparesis</b> <b>436-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chronic Heart Disease</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>2/28</b> 19 <b>80</b> to <b>3/16</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>2/28</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death.)									
22b. SIGNATURE <b>Wm DeWood</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/17/80</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William DeWood, Jr., M.D.</b>				22e. ADDRESS <b>Easton, Md</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>3-19-1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Delmarva Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Lewes, Sussex, Delaware</b>			
24 FUNERAL DIRECTOR NAME <b>Newnam Funeral Home</b>				ADDRESS <b>Easton, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 20 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

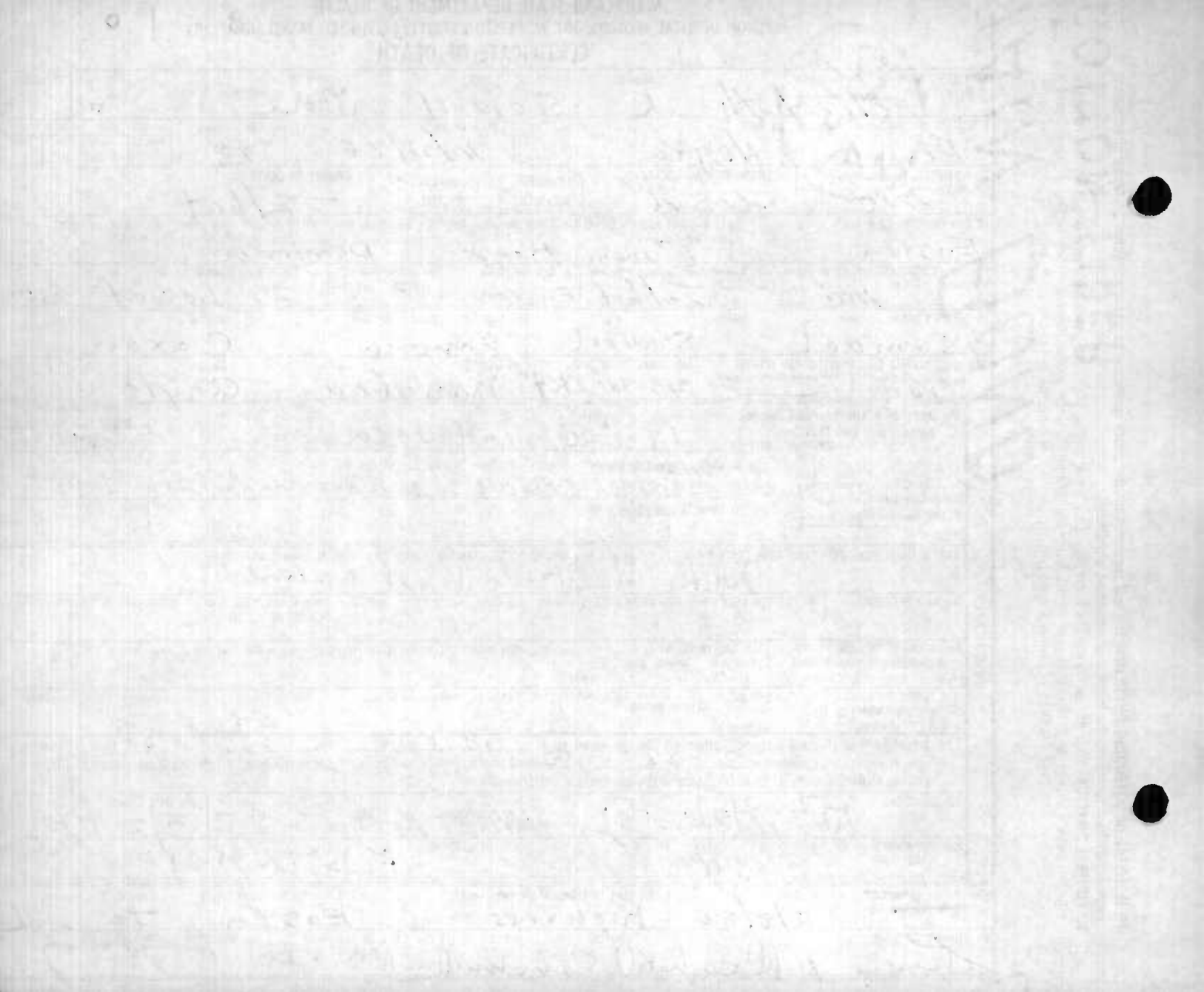
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be kept with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)  
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Elizabeth C Sewall</i>			2a. DATE OF DEATH Month <i>Mar</i> Day <i>2</i> Year <i>80</i>			2b. HOUR M <i></i>											
3. SEX <i>Female</i>		4. RACE <i>Negro</i>		5. DATE OF BIRTH <i>11/21/06</i>		6. AGE (In years last birthday) <i>73</i> YRS.		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		IF UNDER 24 HRS. HOURS <i></i> MIN <i></i>							
7a. BIRTHPLACE (State or foreign country) <i>MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i> Md.											
10. CITY OR TOWN OF DEATH <i>Easton</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Emma Hosp.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Domestic</i>			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>			13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Easton</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>29 Locust St.</i>								
14. FATHER'S NAME First <i>Samuel</i> Middle <i></i> Last <i>Sewell</i>			15. MOTHER'S MAIDEN NAME First <i>Emma</i> Middle <i>Coxen</i> Last <i></i>														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>213-42-244</i>		17. INFORMANT Address <i>Roscoe Boyle</i>												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Arteriosclerosis</i> <i>4029</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Diabetes Mellitus Renal failure</i>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <i>1971</i> , 19 <i>21</i> , to <i>21</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>2-28</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>Wm Howard</i>												22c. ATTENDING PHYS. <i>MD</i>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. DATE SIGNED <i>3/24/80</i>	
22d. PHYSICIAN'S NAME (Type) <i>Wood</i>			22e. ADDRESS <i>Easton, MD</i>														
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <i>2/8/80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Richards</i>			23d. LOCATION (City or Town) (County) (State) <i>Easton Talbot MD</i>									
24. FUNERAL DIRECTOR <i>George H Wood</i>						ADDRESS <i>Easton MD</i>			25a. REC'D BY REGISTRAR DATE <i>APR 01 1980</i>			25b. REGISTRAR'S SIGNATURE <i>John McBrady</i>					





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

08417

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Elizabeth B. SMITH</b>			2a. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>14</b> YEAR <b>1980</b>		2b. HOUR <b>2:05 P.M.</b>
3. SEX <b>Female</b>	4. RACE <b>Cau.</b>	5. DATE OF BIRTH MONTH <b>11</b> DAY <b>24</b> YEAR <b>1893</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Del.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>TALBOT</b> MD.	
10. CITY OR TOWN OF DEATH <b>EASTON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Caroline</b> 13c. CITY OR TOWN <b>Greensboro</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>Maple Ave.</b>	
14. FATHER'S NAME FIRST <b>Albert</b> MIDDLE <b>Billings</b> LAST <b></b>			15. MOTHER'S MAIDEN NAME FIRST <b>Harriett</b> MIDDLE <b>Russell</b> LAST <b></b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>220-03-6011</b>		17. INFORMANT ADDRESS <b>Sue Karcher Greensboro, Md.</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>ASHD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>years</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>3/14</b> 19 <b>80</b> to <b>3/14</b> 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>3/14</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Wm A. Wood</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/2/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William H. Wood, M.D.</b>		22e. ADDRESS <b>Easton, MD 21601</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-17-80</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Denton Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Denton</b> COUNTY <b>Caroline</b> STATE <b>Md.</b>
24. FUNERAL DIRECTOR NAME <b>Wm A. Wood</b> ADDRESS <b>Greensboro, Md.</b>		25. DECEASED BY <b>1980</b> MAR 25			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



Female	Can.	11-24-1893	28
Bel.	U.S.A.	x	
Albert Billings	Ms. Caroline	Greenboro	x
	Wattlett Russell		
no	320-03-6011	and Katcher	Greenboro, N.C.

Houswife

Wattlett Russell

1-17-80  
 Denton Cemetery  
 Denton Caroline N.C.  
 Greenboro, N.C.

# DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

REG. NO.

 FOR  
1- STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST <i>Howard</i> MIDDLE <i>Clyde</i> LAST <i>Spencer</i> <i>Howard C. Spencer</i>			2a DATE OF DEATH MONTH <i>3</i> DAY <i>5</i> YEAR <i>80</i> 7b HOUR <i>6:30 PM</i>		
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH MONTH <i>April</i> DAY <i>13</i> YEAR <i>1895</i>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>West Virginia</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S. A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH <i>Easton</i>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Memorial Hospital</i>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i> MD.	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Carpenter</i>			12b KIND OF BUSINESS OR INDUSTRY		
13a STATE <i>Md.</i>		13b COUNTY <i>Queen Anne's</i>		13c CITY OR TOWN <i>Chester</i>	
14 FATHER'S NAME FIRST <i>Benjamin</i> MIDDLE <i>Bruce</i> LAST <i>Spencer</i>		15 MOTHER'S MAIDEN NAME FIRST <i>Condellia</i> MIDDLE <i>Ann</i> LAST <i>Baben</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b SOCIAL SECURITY NO. <i>219-01-6710</i>		17 INFORMANT ADDRESS <i>Juanita Ruth Spencer, Chester, Md. 21619</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac arrest</i> <i>4149</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>ASCVD - coronary artery disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>+ cerebrovascular insufficiency</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i> <i>years</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>carcinoma of orbit - previous radical (facial) surgery</i>					
19a DATE OF OPERATION <i>—</i>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <i>—</i>	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>—</i>		21f LOCATION STREET CITY OR TOWN COUNTY STATE <i>—</i>	
22a I certify that (I) (this hospital) attended the deceased from <i>3/5/80</i> to <i>3/5/80</i> that (I) (we) last saw the deceased alive on <i>3/5/80</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <i>Albert T. Dawkins Jr. MD.</i>		DEGREE <i>MD.</i>		22c DATE SIGNED <i>3/6/80</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>ALBERT T. DAWKINS JR. MD.</i>		22e ADDRESS <i>14 N. AURORA ST. EASTON, MD. 21601</i>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b DATE <i>3-10-80</i>		23c NAME OF CEMETERY OR CREMATORY <i>Mountain View Cem.</i>	
23d LOCATION CITY OR TOWN COUNTY STATE <i>Marlinton, Pocomoke W. Va.</i>		23e DATE OF REGISTRATION <i>MAR 10 1980</i>			
24 FUNERAL DIRECTOR NAME ADDRESS <i>Heffenbein-Hubbard Funeral Home, Chester, Md. 21619</i>					

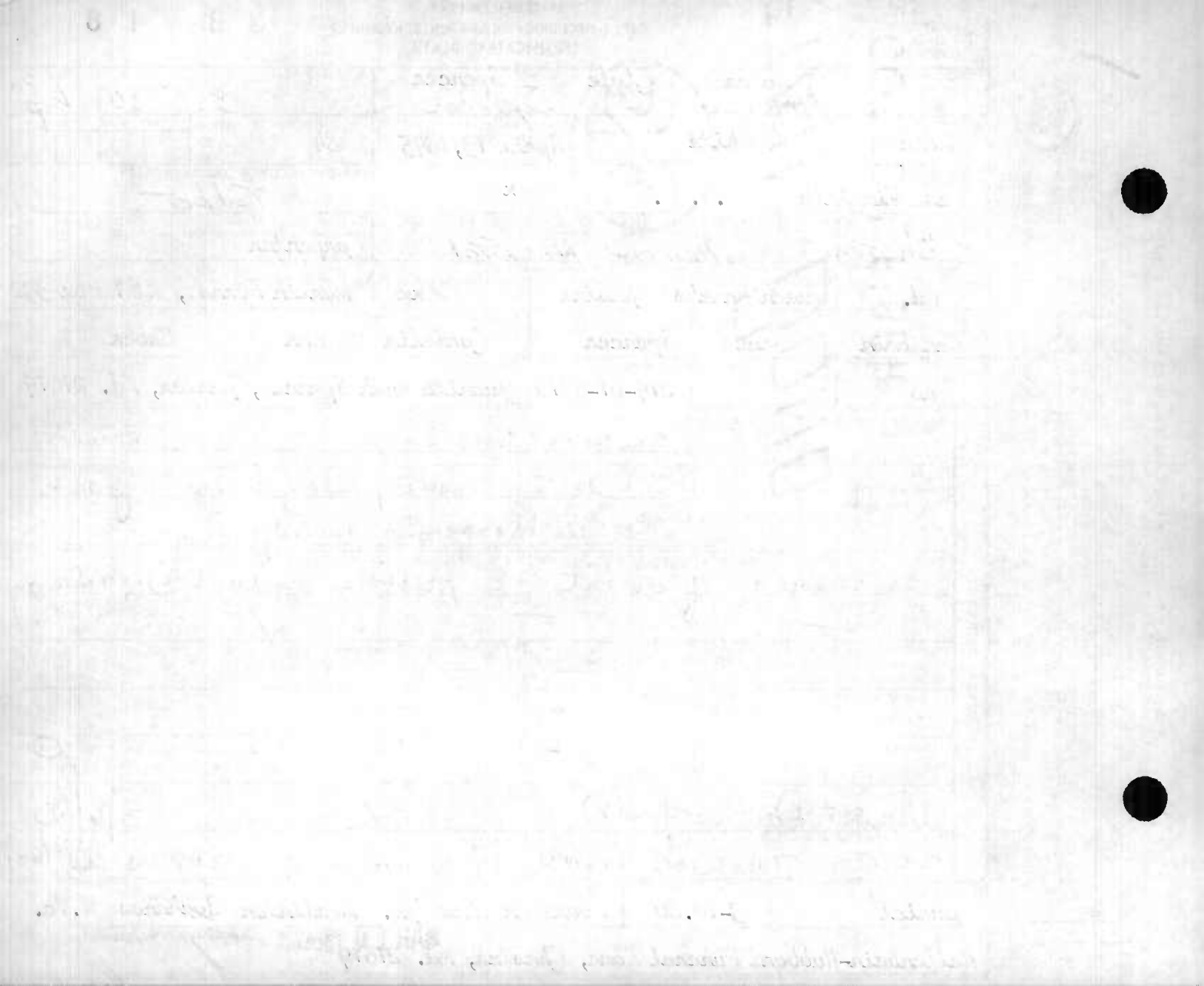
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 008419	
1. FOR STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT) <b>James C STARKEY</b>				2a DATE OF DEATH MONTH DAY YEAR <b>3 28 80</b>			2b HOUR <b>7:25</b> <b>PM</b>	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>October 3, 1892</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD					
10 CITY OR TOWN OF DEATH <b>Easton</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Easton Memorial Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer (retired)</b>		12b KIND OF BUSINESS OR INDUSTRY <b>General Farming</b>			
13a STATE <b>Maryland</b>		13b COUNTY <b>Queen Anne's</b>		13c CITY OR TOWN <b>Centreville</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS <b>R.D. #1, Box 143</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>James Baggs Starkey</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cora Hayes Watts</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>220-34-9854</b>		17 INFORMANT <b>Wife</b> ADDRESS <b>R.D. #1, Box 143</b> <b>Mrs. Mollie R. Starkey, Centreville, Md. 21617</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Prostate</b> <b>185-</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Central Arteriosclerosis</b>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <b>3/28</b> 19 <b>80</b> , saw the deceased alive on <b>3/28</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <b>Wm H Wood</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED <b>3/28/80</b>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Wm H Wood</b>		22e ADDRESS <b>Easton, Md.</b>									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>Mar. 30, 1980</b>		23c NAME OF CEMETERY OR CREMATORY <b>Church Hill</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Church Hill, Q.A. Co., Md.</b>					
24 FUNERAL DIRECTOR NAME <b>Barton Bros.</b>		ADDRESS <b>James H. Barton, Jr., Centreville, Md. 21617</b>		25a DATE REC'D. BY REGISTRAR <b>APR 2 1980</b>		25b REGISTRAR'S SIGNATURE <b>Dorothy McCreedy</b>					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

08420

FOR  
1 - STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph L. Sutton			2a DATE OF DEATH MONTH DAY YEAR March 29, 1980			2b HOUR 4 <sup>00</sup> P. M.				
3 SEX Male		4 RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 10 15 84		6 AGE (IN YEARS LAST BIRTHDAY) 95 YRS		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Talbot MD				
10 CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Memorial Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) L = Gen sv		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md			13b COUNTY Talbot		13c CITY OR TOWN Easton		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS Rte 1 Box 598	
14 FATHER'S NAME FIRST MIDDLE LAST Joseph Sutton				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Melissa Flamer						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b SOCIAL SECURITY NO. —		17 INFORMANT Dola Hayman				
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4379 Cerebrovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) old age Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 94 yrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3-27-80 to 3-29-80, that (I) (we) lost saw the deceased alive and above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Thomas Fauntleroy				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/1/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas Fauntleroy, M.D.				22e. ADDRESS Easton, Md. 21601						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 4/13/80		23c. NAME OF CEMETERY OR CREMATORY Unionville			23d. LOCATION CITY OR TOWN COUNTY STATE Easton TA Md		
24. FUNERAL DIRECTOR NAME ADDRESS George H. H. ... Easton, Md.						25a. DATE REC'D. BY REGISTRAR APR 8 1980		25b. REGISTRAR'S SIGNATURE Fitzroy McBrady		

MEDICAL CERTIFICATION

Thomas F. Kennedy, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO.				0 8 4 2 1		
1 DECEASED NAME (TYPE OR PRINT) JUDGE			FIRST MIDDLE LAST TAYLOR			2a DATE OF DEATH MONTH DAY YEAR 3 7 80			2b HOUR 10:40 A
3 SEX MALE		4 RACE NEGRO		5 DATE OF BIRTH MONTH DAY YEAR MARCH 14, 1904		6 AGE (IN YEARS, LAST BIRTHDAY) 75 YRS.		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) ARKANSAS		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH TALBOT COUNTY MD.			
10 CITY OR TOWN OF DEATH EASTON, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL, EASTON, MD.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SELF-EMPLOYED		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE MARYLAND		13b COUNTY TALBOT		13c CITY OR TOWN ST. MICHAELS		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 102 TALBOT ST.	
14 FATHER'S NAME FIRST MIDDLE LAST JOHN TAYLOR				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b (IF YES, GIVE WAR OR DATES) -----		16c SOCIAL SECURITY NO 243-03-0532		17 INFORMANT ADDRESS 102 TALBOT ST. BEATRICE TAYLOR ST. MICHAELS, MARYLAND			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4439 Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Gangrene of leg DUE TO, OR AS A CONSEQUENCE OF (c) Peripheral Vascular Insufficiency APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 2 week Pern									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22 I certify that (I) (this hospital) attended the deceased from 3/7/80 to 3/7/80, that (I) (we) lost saw the deceased alive on 3/7/80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Wm B Wood				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 3/7/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) WOOD				22e ADDRESS EASTON, MD					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE MARCH 12, 1980		23c NAME OF CEMETERY OR CREMATORY THOMAS MEMORIAL		23d LOCATION CITY OR TOWN COUNTY STATE ST. MICHAELS TALBOT MD.			
24 FUNERAL DIRECTOR NAME Harmon E. Lerner				ADDRESS St. Michaels, Md.		25a DATE REC'D. BY REGISTRAR MAR 13 1980		25b REGISTRAR'S SIGNATURE R. H. McPherson	

BP



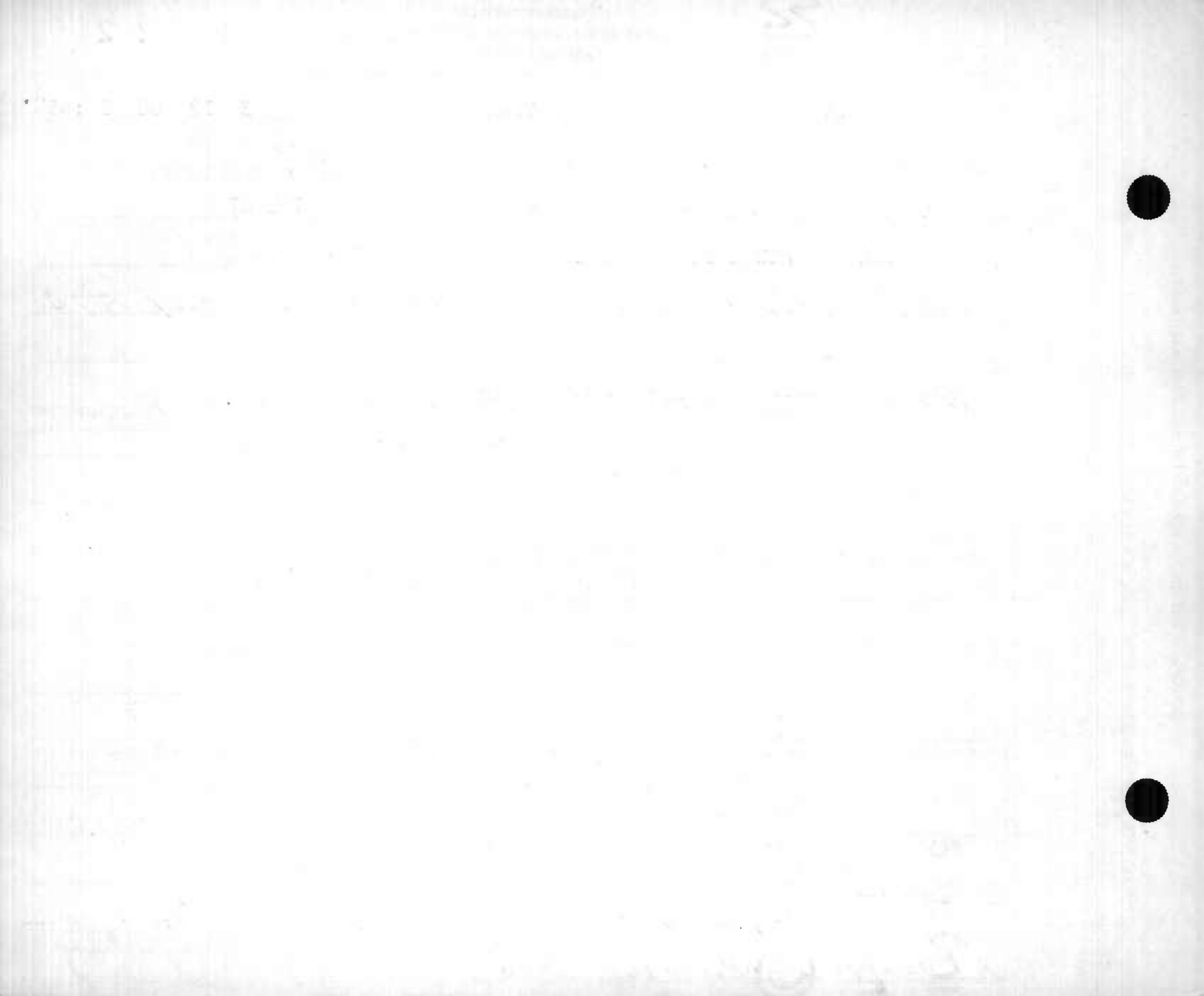
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO.		0 8 4 2 2							
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR		
ULYSSES			TAYLOR			3 18 80			10:45 A.M.		
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
male		Negro		8 6 02		77 YRS		MONTHS DAYS		HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
md		USA				TALBOT MD.					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
EASTON			HOUSE IN THE PINES			Laborer					
13a STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS		
md			Talbot		Easton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R # 1 Box 570		
14 FATHER'S NAME FIRST MIDDLE LAST				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
A											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS					
No				21432-2453		Mobile				Kang	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Insufficiency</u> 4370 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Cerebral Arteriosclerosis</u> (c) <u>Due to, or as a consequence of</u> 1 yr										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>ASD with Cardiac Arrhythmia</u>											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
			P.M. 19								
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>3/1/80</u> to <u>3/18/80</u> , that (I) (we) last saw the deceased alive on <u>3/1/80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED		
Wm Wood			MD						3/19/80		
22d PHYSICIAN'S NAME (TYPE OR PRINT)			22e ADDRESS								
Wood			EASTON, MD								
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE				
			3/22/80		Richards		Easton TA MD				
24 FUNERAL DIRECTOR NAME ADDRESS						25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
George H. DeWitt Easton MD						APR 01 1980		[Signature]			

BP \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 08423			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Charles m Thume				2b. HOUR 11:55 AM			
3. SEX m		4. RACE w		5. DATE OF BIRTH MONTH DAY YEAR Jan. 29, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.	
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) carpenter		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Trappe		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Otto Thume		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Baynard		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			
16b. SOCIAL SECURITY NO. 213-16-8442		17. INFORMANT Margaret A. Thume		17. ADDRESS see item 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 0119 ACTIVE PULMONARY TUBERCULOSIS DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YRS ?			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, did not view the body after death.)							
22b. SIGNATURE (Signature) DEGREE MD				22c. DATE SIGNED 3-18-80		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD E. BAUER				22f. ADDRESS MEMORIAL HOSPITAL EASTON MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-21-1980		23c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Oxford, Talbot, Md.	
24. FUNERAL DIRECTOR NAME Newnam Funeral Home				24. ADDRESS Easton, Md.			





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

08424

 FOR  
 1. STATE  
 REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Stanley E. Treadwell</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 2, 1980</b>		2b. HOUR <b>12:25 AM</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JAN. 7 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>TALBOT CO. MD.</b>	
10. CITY OR TOWN OF DEATH <b>Easton</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>EASTON MEMORIAL HOSP.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>EXPEDITER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>ARUNDEL CORP.</b>
13a. STATE <b>MD</b>	13b. COUNTY <b>TALBOT</b>	13c. CITY OR TOWN <b>OXFORD</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>RHONDA AVE.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>HENRY TREADWELL</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BERTHA TEMPLE</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217-03-3942A</b>			
17. INFORMANT <b>Mr. Tony Treadwell Rhonda Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of lung -</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 19, 1980</b> to <b>Mar 2, 1980</b> , that I (we) last saw the deceased alive on <b>3/2</b> , 19 <b>80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Richard F. Manegold</b>		DEGREE		22c. DATE SIGNED <b>3/3/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Richard F. Manegold</b>		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-5-1980</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BOHEMIAN NATIONAL CH.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO MD</b>
24. FUNERAL DIRECTOR NAME <b>Hartly Miller Funeral Home</b>		ADDRESS <b>2334 JEFFERSON ST.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 5 1980</b>	
25b. REGISTRAR'S SIGNATURE <b>Hartly Miller</b>					

MEDICAL CERTIFICATION

 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

Richard T. Mangold

Richard T. Mangold

2/3

Feb 19 80

Mar 2 80

1 80

2/3/80

Remains of body



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <i>MARGARET</i>			2a DATE OF DEATH MONTH <i>MARCH</i> DAY <i>23</i> YEAR <i>1980</i>			2b HOUR <i>7:05</i> AM	
3 SEX <i>female</i>		4 RACE <i>Cau.</i>		5 DATE OF BIRTH MONTH <i>12</i> DAY <i>23</i> YEAR <i>1899</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>80</i> YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i> MD.	
10 CITY OR TOWN OF DEATH <i>EASTON</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Memorial Hospital</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
13a STATE <i>Md.</i>		13b COUNTY <i>Caroline</i>		13c CITY OR TOWN <i>Greensboro</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST <i>Louis</i> MIDDLE <i>Kibler</i> LAST				15. MOTHER'S MAIDEN NAME FIRST <i>Lizzie</i> MIDDLE <i>Schreiber</i> LAST			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b SOCIAL SECURITY NO <i>216-01-9709</i>		17 INFORMANT ADDRESS <i>Raymond Vogt Greensboro, Md.</i>			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) *410- Congestive Heart Failure*  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b) *Acute Myocardial Infarction*

(c)

*2 wk**2 wk*

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

*Coronate Bradycardia*

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <i>7/19</i> 19 <i>80</i> , to <i>3/23</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>3/22</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b SIGNATURE <i>P. Gregg Rhodes</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <i>3/23/80</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>P. GREGG RHODES M.D.</i>				22e ADDRESS <i>14 N. Aurora - Easton, Md 21601</i>			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		23b DATE <i>3-26-80</i>		23c NAME OF CEMETERY OR CREMATORY <i>Holy Cross</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>Greensboro Caroline Md.</i>	
24 FUNERAL DIRECTOR NAME <i>John E. Bowles</i> ADDRESS <i>Greensboro</i>				25a DATE REC'D. BY REGISTRAR <i>MAR 28 1980</i>		25b REGISTRAR'S SIGNATURE <i>Patricia Rhodes</i>	

Greenboro Caroline Md.

3-26-80 Holy Cross

partial

no 215-01-9709 Raymond Vott Greenboro, Md.

Louis Kipfer

Lizette Schreiber

Md. Caroline Greenboro x Knitebox Rd.

horsewife none

Md. U.S.A.

x

Can. 12-23-1899

80

female

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

08426

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) William H. Waters Jr.			2a. DATE OF DEATH MONTH DAY YEAR March 2 1980			2b. HOUR 10 <sup>50</sup> P.M.	
3 SEX M		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 4 24 1910		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.	
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY SRA Food	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md				13b. COUNTY Som		13c. CITY OR TOWN Kingston	
14. FATHER'S NAME FIRST MIDDLE LAST William H. Waters Sr		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Victory		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-01-4629		17. INFORMANT DEAN WATERS Balt. Md.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-23-80
---	--	---

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2/24/80</u> , 19____, to <u>3/3/80</u> , 19____, that (I) (we) last saw the deceased alive on <u>3/2/80</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE C. W. Bain				DEGREE MD		22c. DATE SIGNED 3/2/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. W. Bain				22e. ADDRESS Easton, Md, 21601			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/8/80		23c. NAME OF CEMETERY OR CREMATORY WATERS CHAPEL		23d. LOCATION CITY OR TOWN COUNTY STATE Kingston Md	
24. FUNERAL DIRECTOR NAME ADDRESS Anthony E. Howard Cripe, MD.				25a. DATE REC'D. BY REGISTRAR MAR 6 1980		25b. REGISTRAR'S SIGNATURE Anthony E. Howard Cripe	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

08427

1. FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>JOHN S. WATSON</b>		2a DATE OF DEATH MONTH DAY YEAR <b>March 16, 1980</b>		2b HOUR <b>4 A. M.</b>	
3 SEX <b>male</b>		4 RACE <b>caucasian</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Mar. 19, 1885</b>	
6 AGE (IN YEARS LAST BIRTHDAY) <b>94</b> YRS		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Scotland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD			
10 CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>R.D. #3, Box 489</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>real estate salesperson</b>	
13a STATE <b>Maryland</b>		13b COUNTY <b>Talbot</b>		13c CITY OR TOWN <b>Easton</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Alexander Watson</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Sadler</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>218-12-1025</b>		17 INFORMANT ADDRESS <b>Dorothy W. Watson see item 13</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>4140</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 yrs.</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. I certify that (1) this hospital attended the deceased from _____, 19____, to _____, 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did not) examine the body after death.		21h. SIGNATURE DEGREE <b>J. Thomas Craighead, M.D.</b>	
21i. PHYSICIAN'S NAME (TYPE OR PRINT)		21j. ADDRESS		22c. DATE SIGNED <b>3/17/80</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-19-1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Easton, Talbot, Md.</b>		24 FUNERAL DIRECTOR NAME <b>Neenam Funeral Home</b>		25. REGISTRAR'S SIGNATURE <b>Mar 20 1980</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5, entry for retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please send the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examination must be notified at once.

BP

11 8 5 2

11 8 5 2

11 8 5 2

11 8 5 2

11 8 5 2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				0 8 4 2 8			
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1 DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
EDWARD MARMADUKE WHALLEY				3 23 80 10 <sup>22</sup> AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
male		caucasian		Sept. 18, 1892		87 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
New Jersey		U.S.				TALBOT COUNTY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
EASTON, MD.		MEMORIAL HOSPITAL		Prod. Supr.		manufacturing	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN	
Maryland				Talbot		Oxford	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Edward Whalley				Emma B. Tilden			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
yes		W.W. 1		Marjorie C. Whalley		Box 243 Oxford, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i> 436- DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized Atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>acute</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Obstructive emphysema 3° to BPH</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <i>3-17</i> 19 <i>80</i> to <i>3-23</i> 19 <i>80</i> , that (I) (we) (us) saw the deceased alive on <i>3/23</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE <i>Richard F. Manegold</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-24-1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard F. Manegold, M.D.				22e. ADDRESS Easton, Md. 21601			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Cremation		3-26-1980		Delmarva Crematory		Lewes, Sussex, Delaware	
24. FUNERAL DIRECTOR NAME Newham Funeral Home				ADDRESS Easton, Md.		25a. DATE REC'D. BY REGISTRAR MAR 28 1980	
				25b. REGISTRAR'S SIGNATURE <i>Henry McCreary</i>			

RECEIVED

DATE

Carbonaceous Residue  
Synthetic Resin

Obtained by heating 2 to 5% H<sub>2</sub>

100 1 - 3/23

2-17

3/23

Charles E. Hoyle

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

08429

1. FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Sda B Willey</i>			2a DATE OF DEATH MONTH DAY YEAR <i>3-10-80</i>		2b HOUR <i>11</i> M		
3 SEX <i>female</i>		4 RACE <i>caucasian</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>May 15, 1888</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>91</i> YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i> MD.	
10 CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Memorial Hospital</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>housewife</i>		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE <i>Maryland</i>		13b COUNTY <i>Talbot</i>		13c CITY OR TOWN <i>Bozman</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>Benjamin Frank Marsahil</i>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Laura Hancock</i>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b SOCIAL SECURITY NO. <i>214-74-7131</i>	
17 INFORMANT ADDRESS <i>Cora W. Harrison Bozman, Md.</i>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> <i>4140</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Hypertensive and arteriosclerotic</i> (c) <i>Heart disease</i> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Uncertain</i>		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>none</i>			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (1) (this hospital) attended the deceased from <i>3-2-80</i> 19 <i>80</i> to <i>3-10</i> 19 <i>80</i> , that (1) (we) lost saw the deceased alive on <i>3-10</i> 19 <i>80</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did not view the body after death.		22b SIGNATURE <i>Robert W. Trever, M.D.</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>3-11-80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert W. Trever, M.D.</i>		22e ADDRESS <i>R.D. 3 Easton, Md. 21601</i>		23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b DATE <i>B-13-1980</i>	
23c NAME OF CEMETERY OR CREMATORY <i>Olivet Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>St. Michaels, Talbot, Md.</i>		24 FUNERAL DIRECTOR NAME <i>Newnam Funeral Home</i>		ADDRESS <i>Easton, Md. 21601</i>	

MAR 17 1980

Robert W. Trever, M.D.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

0 8 4 3 0

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>DEAN HARRISON WILLIAMS</b>			2a DATE OF DEATH MONTH DAY YEAR <b>March 3, 1980</b>			2b HOUR <b>4 A. M.</b>			
3 SEX <b>male</b>		4 RACE <b>caucasian</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Nov. 16, 1913</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>66</b>		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.			
10 CITY OR TOWN OF DEATH <b>Cordova</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>R.D. #1, Box 243A</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>carpenter</b>		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE <b>Maryland</b>			13b CITY OR TOWN <b>Talbot</b>		13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d STREET ADDRESS <b>R.D. #1, Box 243A</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>James E. Williams</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth A. Calloway</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>W.W. 11</b>		17 INFORMANT ADDRESS <b>John F. Williams, Sr. Cordova, Md.</b>				

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cor Pulmonale</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b>	
DUE TO OR AS A CONSEQUENCE OF (b) <b>Chronic Obstructive Pulm. Disease</b>		<b>Years</b>	
DUE TO OR AS A CONSEQUENCE OF (c) <b>Acid Fast Disease (T.B.) - old</b>		<b>many years.</b>	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

**Emaciation**

19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 3, 19 77</b> to <b>Feb 14, 19 80</b> , that (I) (we) lost saw the deceased alive on <b>Feb 14, 19 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Ch. H. Seibert</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/4/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Anne H. Webb, M.D.</b>				22e. ADDRESS <b>400 Dutchman's Lane Easton, Md.</b>			

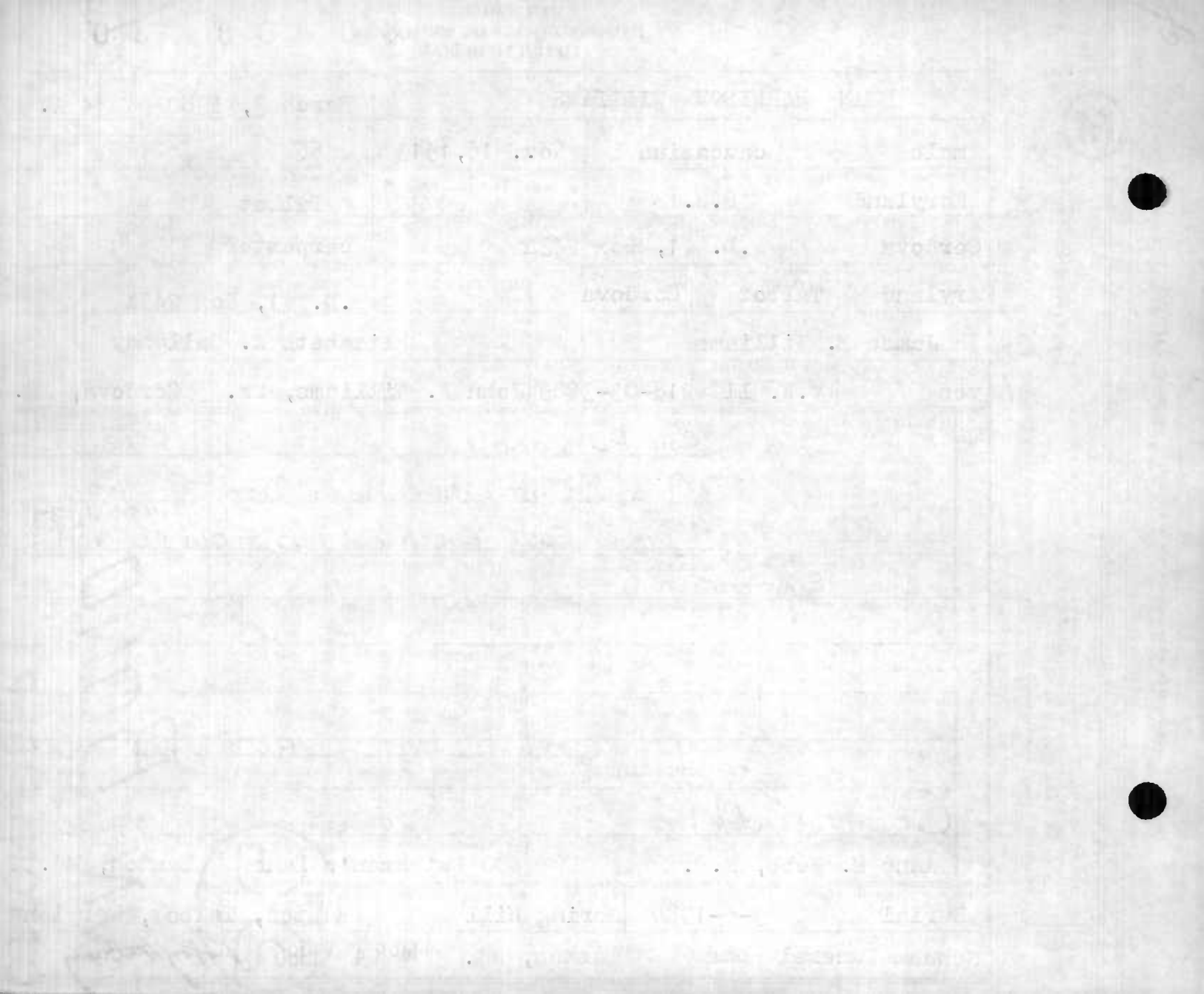
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-6-1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Easton, Talbot, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Newham Funeral Home</b>				ADDRESS <b>Easton, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 4 1980</b>	
				25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Post-mortem retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrator, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar's death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Bobby Girl Wilmer</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3 27 80</i>			2b. HOUR <i>12 15 PM</i>			
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>3 27 80</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>1 19</i>		7. UNDER 1 YEAR HOURS MIN. <i>1 19</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Taibot</i> MD.			
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Memorial Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Caroline</i>		13c. CITY OR TOWN <i>Prester</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>Rt. 2, Box 202a</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Robert O. Watkins</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Linda M. Wilmer</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cordoc 1 Bsg. Arrest</i> <i>7798</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Sanctuary</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Sanctuary</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <i>March 27, 1980</i> , to <i>March 27, 1980</i> , that (I) (we) last saw the deceased alive on <i>March 27, 1980</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Regis Storch</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>3-27-80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Regis Storch, M.D.</i>						22e. ADDRESS <i>Easton, Md. 21601</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME <i>Regis Storch</i>						25a. DATE REC'D. BY REGISTRAR <i>APR 3 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Regis Storch</i>	

BP

1881

no. 2. 1881

1881

Easton, Md. 21801

Regis Storch, M.D.

*Regis Storch*

APR 3 1881

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items 21a&22a G542 4/25/80 dad STATE OF MARYLAND  
 08432

1- FOR STATE REGISTRAR  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Margaret Wright</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3-29-80</i>			2b. HOUR <i>1:55 AM</i>	
3 SEX <i>Female</i>		4 RACE <i>Cauc.</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>July 4, 1907</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>72</i> YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i> MD	
10 CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Memorial Hospital</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <i>Maryland</i>		13b COUNTY <i>Caroline</i>		13c CITY OR TOWN <i>Denton</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>Harry C. Hopkins</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mae Elben</i>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			
16b SOCIAL SECURITY NO. <i>212747924</i>		17 INFORMANT ADDRESS <i>Rena Nordberg, Rt.2 Box 263, Preston</i>					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <i>410</i> IMMEDIATE CAUSE (a) <i>Cardiorespiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Aspiration of gastric contents</i> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>ASCVD w/ recent Myocardial infarction</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>3/23</i> 19 <i>80</i> to <i>3/27</i> 19 <i>80</i> , that (I) (we) lost saw the deceased alive on <i>3/23</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. <i>Natural</i>							
22b. SIGNATURE <i>William J. Banfield</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>William J. Banfield</i>		22e. ADDRESS <i>400 Dutchmans Lane, Easton, Md</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3/30/80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Denton Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Denton Caroline MD</i>	
24. FUNERAL DIRECTOR NAME <i>MOORE FUNERAL HOME</i>		24b. DATE REC'D. BY REGISTRAR <i>185 2nd St</i>		24c. REGISTRAR'S SIGNATURE <i>21229</i>		25. DATE REC'D. BY REGISTRAR <i>MAR 31 1980</i>	

U.S. DEPARTMENT OF JUSTICE

Division of Investigation

Washington, D.C. 20535

February 10, 1961

Mr. J. Edgar Hoover, Director